

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF MASSACHUSETTS

JOHN HANCOCK LIFE INSURANCE)	
COMPANY, JOHN HANCOCK)	
VARIABLE LIFE INSURANCE)	
COMPANY, and MANULIFE INSURANCE)	
COMPANY (f/k/a INVESTORS)	
PARTNER LIFE INSURANCE)	
COMPANY),	)	CIVIL ACTION NO. 05-11150-DPW
)	
Plaintiffs,)	
)	
v.)	
)	
ABBOTT LABORATORIES,)	
)	
Defendant.)	
)	

JOHN HANCOCK'S LIST OF DEPOSITIONS TO BE USED
AT TRIAL IN ITS CASE-IN-CHIEF

CONTINUATION OF EXHIBITS

ANGELA LANDSBERG
Abbott Senior Manager
New Product Development
ABT-594

JOHN HANCOCK'S DEPOSITION DESIGNATIONS

ANGELA LANDSBERG
Abbott Senior Manager
New Product Development
February 16, 2007

FROM	TO	EXHIBIT
p. 4, l. 6	p. 4, l. 7	None
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p. 11, l. 20	p. 15, l. 9	None
p. 20, l. 8	p. 20, l. 19	None
p. 28, l. 1	p. 28, l. 4	None
p. 29, l. 18	p. 30, l. 3	None
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p. 110, l. 3	p. 111, l. 16	Dep. Ex. 11/ PLs' DG
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p. 196, l. 4	p. 197, l. 17	Dep. Ex. 28/ PLs' EL
p. 202, l. 11	p. 202, l. 18	None
p. 203, l. 20	p. 206, l. 20	None

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF MASSACHUSETTS
3 JOHN HANCOCK LIFE INSURANCE)
4 COMPANY, JOHN HANCOCK VARIABLE)
5 LIFE INSURANCE COMPANY, and)
6 MANULIFE INSURANCE COMPANY)
7 (f/k/a INVESTORS PARTNER)
8 INSURANCE COMPANY),)
9 Plaintiffs,) Civil Action No.
10 vs.) 05-11150-DPW
11 ABBOTT LABORATORIES,)
12 Defendant.)

13

14 The videotaped deposition of **ANGELA**
15 **LANDSBERG**, called for examination, taken pursuant to
16 the provisions of the Federal Rules of Civil
17 Procedure of the United States District Courts
18 pertaining to the taking of depositions for the
19 purpose of discovery, taken before Barbara J.
20 Cramer, CSR No. 84-1700, a Certified Shorthand
21 Reporter of the State of Illinois, at Suite 1300,
22 Two North LaSalle Street, Chicago, Illinois, on the
23 16th day of February, A.D. 2007, at 10:26 a.m.

24

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1 MR. ELSEY: We are on the video record, yes.

2 ANDREA LANDSBERG,

3 called as a witness herein, having been first duly

4 sworn, was examined and testified as follows:

5 EXAMINATION

6 BY MR. DAVIS:

7 Q. Okay. Good morning.

00005

17 Q. Would you state your full name for the
18 record, please?

19 A. Yes. Andrea Landsberg.

20 Q. Where do you live, Ms. Landsberg?

21 A. The whole address?

22 Q. Yes, please.

23 A. 23494 Eagles Nest Road, Antioch,
24 Illinois, 60002.

00006

1 Q. Where do you work?

2 A. Abbott Laboratories. I should say
3 "Abbott" now is our correct name.

00006

18 How long have you worked for Abbott?

19 A. It's about ten and a half years.

20 Q. What -- what position do you currently
21 hold at Abbott?

22 A. General manager, primary care and
23 emerging markets for Abbott International.

24 Q. Is that a -- do you work within a

00007

1 particular division of Abbott?

2 A. Yes, Abbott International Division.

3 Q. What is the business of Abbott

4 International?

5 A. Pharmaceuticals, marketing and sales of
6 pharmaceuticals outside of the US.

7 Q. Is it fair to say that your job focuses
8 primarily on marketing and sales?

9 A. Yes.

10 Q. Has that been true all of time that
11 you've worked for Abbott in one capacity or another?

12 A. I'm running through all of my jobs in my
13 head. Yes.

14 Q. Are you -- is your office at Abbott Park?

15 A. Yes, it is.

16 Q. Briefly, what's your educational
17 background?

18 A. I have a B.S. in biology from Cook
19 College, Rutgers University. I have a V.M.D. from
20 University of Pennsylvania, and I have an M.B.A.
21 from Morgan, University of Pennsylvania, in that
22 order. I know; doctorate before the Master's.

23 Q. I'm sorry. What was the doctorate in?

24 A. Veterinary medicine.

00008

1 Q. What year did you obtain the B.S. from
2 Rutgers?

3 A. '84.

4 Q. When did you obtain the doctorate?

5 A. '88.

6 Q. And when did you obtain the M.B.A.?

7 A. '96.

8 Q. Did you go to work for Abbott for the
9 first time after you obtained your M.B.A.?

10 A. Yes.

11 Q. Had you worked prior to that?

12 A. Yes, as a veterinarian.

13 Q. Briefly, what are the positions that
14 you've held at Abbott, as best you recall, since you
15 joined them about ten years ago?

16 A. Excuse me. Initially on the management
17 development program, a series of positions, market
18 research analyst, sales representative, and then
19 associate product manager. I can define all the
20 products if you need that detail or -- or not.

21 Then continued as a product manager, then
22 a senior product manager, then a senior manager in
23 new product development, and then director of what
24 we called at the time professional communications.

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1 It is a marketing operations group.

2 Q. What was the position again? I'm sorry.

3 A. Director of professional communications
4 was its formal title. We ended up changing the
5 name, because it didn't reflect what it -- I forget
6 what we changed its name to.

7 Q. Okay.

8 A. But it's basically a marketing operations
9 group, supports the marketing functions.

10 And then director for cardiovascular
11 products, and then was called both senior director
12 and then we changed it to a general manager, and the
13 final title was the general manager of the
14 commercial strategic initiatives, a combined sales
15 and marketing excellence role.

16 Q. Any others?

17 A. And then the one that I currently have.

18 Q. When did you take the position -- when
19 did you first assume the position that you're
20 currently in?

21 A. In July of this past year.

22 Q. At some time or another during the course
23 of your tenure at Abbott, you had some involvement
24 in the development of a compound named 594. Is that

00010

1 right?

2 A. Yes.

3 Q. Okay. That's ABT-594. Do you agree with
4 that?

5 A. Yes.

6 Q. And if I refer to it as 594, in the
7 course of your deposition, you'll understand that
8 I'm referring to ABT-594. Is that fair?

9 A. Yes.

10 Q. All right. In which of these positions
11 did you have any responsibility for ABT-594?

12 A. It was the senior manager, new product
13 development.

14 Q. And how long did you hold that position?

15 A. Only about seven months.

16 Q. Do you recall what seven months those
17 were?

18 A. Yeah, I've been trying to think of that.
19 I know I moved into that next position in February
20 of '01, so I'm thinking it must have been June of
21 2000 when I began that position, roughly.

22 Q. And the next position that you moved into
23 was the director of professional communications?

24 A. Yes.

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1 Q. When you became director of professional
2 communications, did your responsibilities for
3 ABT-594 cease?

4 A. Yes.

00011

20 Q. So it's fair to say that all of your
21 involvement with respect to ABT-594 occurred in the
22 period from June of 2000 through -- to February --
23 sometime in February of '01.

24 A. To the best of my recollection, those

00012

1 dates, to the best of my recollection.

2 Q. And what responsibilities did you have
3 with respect to ABT-594?

4 A. It was a role that was designed to

5 provide commercial forecasting and support for any
6 of our pipeline products for, you know, discovery or
7 development products.

8 Q. Okay.

9 A. And I had two areas of responsibility.

10 Q. All right. Is it correct that at the
11 time that you first had any responsibility for 594,
12 that 594 already was under development by Abbott?

13 A. Yes.

14 Q. Were you part of some sort of team that
15 was focused on the development of ABT-594?

16 A. Yes.

17 Q. What was the name of the team?

18 A. I don't remember specifically what it was
19 called.

20 Q. Is it fair to say that your
21 responsibility on the team was to help provide the
22 sort of commercial and marketing support for the
23 development of ABT-594?

24 A. By support, I'm not sure. I mean, that

00013

1 can be very general, but ...

2 Q. I can be more specific. ABT-594 hadn't
3 been introduced to the market at that point in time.
4 Correct?

5 A. Correct.

6 Q. Part of your responsibilities were
7 helping to formulate plans, put together
8 projections, forecasts of that nature that could be

9 utilized by Abbott in deciding whether to introduce
10 ABT-594 and what steps to take in the event that it
11 was introduced. Is that fair to say?

12 MR. LORENZINI: Objection.

13 You can answer.

14 BY THE WITNESS:

15 A. I would say it was to develop the
16 forecasts. Anything that we had in development we
17 would have assumed we would continue to promote. I
18 was developing the plan for the launch of the
19 product.

20 BY MR. DAVIS:

21 Q. And part of developing the plan included
22 forecasting potential sales of the product. Is that
23 right?

24 A. Yes, it did.

00014

1 Q. Who else do you recall working with on
2 that team that was focused on ABT-594?

3 A. On the clinical team, Chris Silber and
4 Bruce McCarthy. And Laura -- and her last name is
5 escaping me -- was my Abbott International
6 counterpart.

7 Q. Laura Robinson?

8 A. Yes. Thank you. Laura Robinson.

9 Q. Who else?

10 A. There was a project team -- I -- I don't
11 know what his name was. He was sort of the -- we
12 call them now sort of project team leaders, so I

13 don't know what his exact title would have been back

14 then. But Mike --

15 Q. Biarnesen?

16 A. -- Biarnesen, yes.

17 Q. All right.

18 A. There were other people, but --

19 Q. All right.

20 A. The only other one I -- I can name is Jim

21 Sullivan, who was in the discovery team.

22 Q. Approximately how many people were on the
23 team all told?

24 MR. LORENZINI: Objection; vague.

00015

1 BY THE WITNESS:

2 A. I -- I -- it would be making a guess. I
3 don't remember. You know, a group of more than the
4 people I have named.

5 BY MR. DAVIS:

6 Q. Somewhere between --

7 A. It's safe to say there are some others.

8 Q. Is it somewhere between 10 and 20 people?

9 A. Yes, probably.

00020

8 Q. Let me -- let me go back for a moment. I
9 just want to make sure I have it clear on the

10 record. What was your role on the ABT-594 team?

11 A. To be the individual who would develop
12 the market forecasts for the product -- or, at this
13 point, compound -- and begin to plan for what a

14 launch would look like, so a preliminary market
15 plan; not as detailed as you would certainly have on
16 an on-market product for its market plan.

17 Q. Did you have any other responsibilities,
18 as best you recall?

19 A. No.

00028

1 Q. While you were working on the 594 team,
2 were you aware that there was a Phase IIb clinical
3 study for neuropathic pain under way?

4 A. Yes.

00029

18 Q. What is your recollection regarding the
19 concerns that were expressed regarding the drop-out
20 rate in that study?

21 MR. LORENZINI: Objection; lacks foundation.

22 BY THE WITNESS:

23 A. My recollection --

24 MR. LORENZINI: If any.

00030

1 BY THE WITNESS:

2 A. That's -- I don't have a personal
3 recollection of that.

00047

7 (WHEREUPON, a certain document was
8 marked Landsberg Deposition Exhibit
9 No. 4, for identification, as of
10 2/16/07.)

11 BY MR. DAVIS:

12 Q. Ms. Landsberg, you have what's been
13 marked as Exhibit 4. Would you look at this
14 document for a moment and tell me if you've ever
15 seen it before?

16 MR. LORENZINI: Objection; instruct the witness
17 not to answer to the extent the question in- --
18 includes seeing the document during our meeting.

19 BY THE WITNESS:

20 A. I do not, in any way, remember seeing
21 this before.

00056

5 Q. Do you see there's a table there entitled
6 "US Forecast, Date of Forecast, 7/00"?

7 A. Yes.

8 Q. What is -- what is that a U.S. forecast
9 of?

10 A. I would assume it's the forecast for 594,
11 since it's in the 594 document.

12 Q. Um-hmm. Where did the information
13 contained in this table come from?

14 A. Specifically the information that is here
15 right now, I couldn't tell you.

16 Q. All right. Where did you typically
17 obtain this kind of information?

18 A. This would have been developed -- and
19 these specific numbers would have been developed
20 either by my predecessor or myself. That's what I
21 don't know, who developed these numbers that are
22 sitting here on this table.

23 Q. How would you go about developing these
24 numbers or numbers like these?

00057

1 A. For any forecast that was done, you would
2 do research on the disease state you were looking
3 at, by reviewing a number of sources. We had both
4 large -- we called them syndicated studies, I think,
5 of companies that put them out, like Decision
6 Resources or Data Monitor.

7 We would purchase those and look at what
8 they said the trends of patient population for the
9 target audience that you were looking at. And they
10 usually have projections over time. So you would
11 start there, kind of, what is my potential patient
12 base for the indication that you're looking at for a
13 product.

14 We could also -- we had access to a
15 number of databases -- I'm not remembering their
16 names -- but -- that have pipeline -- other
17 companies, their compounds that were in discovery or
18 development phases. We would also look at data that
19 we would pull from an IMS source. That's a company
20 that provides data on existing marketed products.
21 So you would take a look at what the existing
22 pattern was.

23 They have information on diagnosis codes
24 for reimbursement and how -- so what a particular

00058

1 product might be prescribe for. I'm getting into
2 more detail than you probably want.

3 But you -- but you take a lot of
4 different sources and come up with your market
5 assessment, you know, that it starts, usually, at
6 this point, with unmarketed products or products
7 that are not on the market yet. You almost always,
8 in my experience, do a patient based forecast.
9 That's why I'm saying you go back to the patient
10 population.

11 Then you look at potential rates of
12 diagnosis. Then you look of everybody who's
13 diagnosed, what are treated, percent of population
14 that might be treated. And then you get into your
15 assessment of your competitive set. So what is out
16 there now and how are they performing, what is out
17 there -- what is potential to come out, and what do
18 analysts say, what do the opinion leaders say, and
19 we look at everything you have and make a judgment
20 based on where you think your product will fit to
21 come up with a market prescription in the end.
22 There's usually a big spreadsheet analysis that you
23 do on this to get this -- these numbers.

24 Q. Okay. It sounds like a fair amount of

00059

1 work associated with this.

2 A. Yes.

3 Q. Okay. And what -- for what reason were

4 these forecasts prepared?

5 A. The reason of knowing whether you should
6 invest in a product. I mean, these are -- this
7 comes back to that portfolio planning process.
8 Where -- what do you think your future stream of
9 revenue will be --

10 Q. Is it your understanding that --

11 A. -- for a compound.

12 Q. -- the data was -- was prepared for the
13 purpose of assisting people within Abbott making
14 intelligent decisions about particular compounds?

15 A. Yeah, that's fair.

16 Q. And in preparing information like this,
17 was it your intention to try to make it as
18 reasonably accurate as you could?

19 A. Of course.

00070

11 (WHEREUPON, a certain document was
12 marked Landsberg Deposition Exhibit
13 No. 6, for identification, as of
14 2/16/07.)

15 BY MR. DAVIS:

16 Q. Ms. Landsberg, would you take a moment
17 and look at the document that has been marked as
18 Exhibit 6? In fact, what I'm going to ask you to do
19 is to take a few moments and read the emails --

20 A. Um-hmm.

21 Q. -- that form the first three pages of
22 Exhibit 6, and then please tell me when you're done

23 reading.

24 A. Okay.

00071

1 Q. Do you remember this exchange of email
2 correspondence back in August of 2000?

3 A. I don't.

00072

23 Q. Well, do you have any reason to believe,
24 as you sit here today, that these email messages

00073

1 were not exchanged among you and others at Abb- --
2 in Abbott in August of 2000?

3 A. No.

00076

11 Q. And one of the things that you state in
12 your email, if you look about two-thirds of the way
13 down your email, you see a paragraph that begins
14 "Forecast assumptions."

15 A. Yes, I see that.

16 Q. And in that paragraph, one of the things
17 you say is that "I'm using this here to be sure we
18 stay very aware of just how important this issue of
19 tolerability is to gain any market share."

20 Do you see that?

21 A. Yes.

22 Q. Now, actually, I should go back. In
23 that -- and that paragraph begins "Forecast
24 assumptions, again, not taking tolerability and

00077

1 safety, to only be applying just to V&N."

2 Do you see that?

3 A. Yes, I do.

4 Q. That V&N, is that a reference to vomiting
5 and nausea?

6 A. Yes, I believe so.

7 Q. And then later on, you say, in the same
8 paragraph, "I'm using this here to be sure we stay
9 very aware of just how important this issue of
10 tolerability is to gain any market share. I also
11 thought that we were assuming the current trial with
12 titration was supposed to greatly reduce the N&V
13 issue," paren, "Please let me know if this is a
14 misunderstanding on my part," close paren.
15 Let me stop there.

16 A. Um-hmm.

17 Q. Now, the reference to N&V there is to
18 nausea and vomiting. Is that right?

19 A. Yes, I believe so.

20 Q. And what was the nausea and vomiting
21 issue associated with ABT-594 as of August 2000?

22 A. I don't recall specifically. I don't
23 recall in general. I'm sorry. I don't recall. I
24 don't recall.

00078

1 Q. And when you say, "We were -- we were
2 assuming the current trial with titration was
3 supposed to greatly reduce the nausea and vomiting

4 issue," are you referring to the 114 trial?

5 A. I would assume that being the current
6 trial under way at that time, yes.

7 Q. You go on to state in the same email, "I
8 know we have some definite signs that that is likely
9 not the case," paren, "re early discontinuations,"
10 close parens, "but should we be adjusting
11 assumptions before we really have all the data
12 analyzed," question mark.

13 Do you see that?

14 A. Yes, I do.

15 Q. Now, who -- how did you become aware that
16 there were some definite signs at that point in time
17 that the 114 trial was going to -- well, strike
18 that.

19 What were the definite signs that you
20 refer to in that section?

21 MR. LORENZINI: Objection; lacks foundation.

22 BY THE WITNESS:

23 A. I don't recall, but I -- right here,
24 you -- it says "re early discontinuations."

00080

16 Q. It says, "I also thought that we were
17 assuming the current trial with titration" --

18 A. Um-hmm.

19 Q. -- "was supposed to greatly reduce the
20 nausea and vomiting issue," paren, "please let me
21 know if this is a misunderstanding on my part,"
22 close paren. "I know we have --

23 A. Um-hmm.

24 Q. -- "some definite signs that that is

00081

1 likely not the case," paren, "re early

2 discontinuations," close paren.

3 So the early discontinuations were a

4 definite sign that -- if I -- do I have it correct

5 that the early discontinuations were considered to

6 be a definite sign that the 114 trial was not going

7 to result in a reduction in nausea and vomiting?

8 MR. LORENZINI: Objection; lacks foundation,

9 mischaracterizes the document.

10 BY THE WITNESS:

11 A. I think I can sit here and interpret the

12 sentence just as you are attempting to interpret the

13 sentence. But I can't say that I know what was

14 going through my head at this point in time, so what

15 is there is there.

16 BY MR. DAVIS:

17 Q. Do you have any recollection, as you sit

18 here today, what it was that you were talking about

19 when you said that you had definite signs from the

20 114 trial as of August 2000 that something was

21 likely not the case?

22 MR. LORENZINI: Objection.

23 BY THE WITNESS:

24 A. I -- I'm -- I'm still not following that.

00082

1 Q. I'm trying to --

2 A. What the definite signs are? As I said,
3 I think the definite signs I would have been
4 referring to here are the early discontinuations.

00083

19 Q. Do you have any recollection of
20 discussions within Abbott regarding data from the
21 114 trial or the potential meaning of any data from
22 the 114 trial before that -- the final results of
23 that trial were unblinded?

24 MR. LORENZINI: Objection; vague and ambiguous.

00084

1 BY THE WITNESS:

2 A. No. My recollection of the early
3 discontinuation discussions or information would
4 have been we were tracking the progress of the
5 trial.

6 BY MR. DAVIS:

7 Q. Um-hmm.

8 A. I recall us tracking the progress of the
9 trial.

00085

14 Q. You mentioned a moment ago that you were
15 tracking the progress of the trial, meaning the 114
16 trial. Right?

17 A. Yes.

18 Q. What did you mean by that? What was
19 Abbott doing in tracking the progress of that trial?

20 A. We do this frequently to track enrollment
21 and number of patients to know are you going to stay
22 on your time line, most -- most typically, is what
23 you're tracking for.

00087

5 Q. So it's okay for me to talk about Abbott
6 tracking the trials. Is that right? You agree that
7 Abbott tracked the progress of the 114 trial.

8 A. If you mean the clinical team on the
9 trial -- trial, yes.

10 Q. And the information that they obtained
11 when tracking the trial was shared with other
12 members of the 594 team, including you?

13 A. Yes, as we've seen.

14 Q. And one of the things that they were
15 tracking were early discontinuations. Is that
16 right?

17 A. Yes.

18 Q. And is it fair to say that, as of August
19 of 2000, you took the early discontinuations to be a
20 definite sign that the 114 trial with titration was
21 not going to greatly reduce the nausea and vomiting
22 issue that was associated with the use of ABT-594?

23 A. Some definite --

24 MR. LORENZINI: Objection.

00088

1 BY THE WITNESS:

2 A. "Some definite signs" to me, yeah, I was
3 probably being -- I don't know anymore what "some

4 definite signs" mean, but --

5 BY MR. DAVIS:

6 Q. Okay.

7 A. -- I was probably being hyperbole there.

8 Q. Well, can you answer my question --

9 A. I'm sorry.

10 Q. -- which is, did you -- is it fair to say

11 that, as of August 2000, you took the early

12 discontinuations that had been observed in tracking

13 the 114 trial to be a definite sign -- not

14 necessarily the only sign, but a definite sign --

15 that the 114 trial with titration was not going to

16 greatly reduce the nausea and vomiting issue that

17 had been observed with ABT-594?

18 MR. LORENZINI: Objection.

19 BY THE WITNESS:

20 A. In looking at this sentence, it seems

21 that I may have.

22 BY MR. DAVIS:

23 Q. Do you believe you did?

24 MR. LORENZINI: Objection; lacks foundation.

00089

1 BY THE WITNESS:

2 A. It's odd when you don't remember

3 something to be able to say -- reflect now on it. I

4 don't remember it. I'm interpreting the sentence.

5 BY MR. DAVIS:

6 Q. But looking at it today, that's what you

7 think you meant. Right?

8 MR. LORENZINI: Objection.

9 You can answer.

10 BY THE WITNESS:

11 A. Yeah, I guess.

00104

13 (WHEREUPON, a certain document was

14 marked Landsberg Deposition Exhibit

15 No. 10, for identification, as of

16 2/16/07.)

17 BY MR. DAVIS:

18 Q. Ms. Landsberg, you have what's been

19 marked as Exhibit 10 at your deposition.

20 A. Um-hmm.

21 Q. Would you please take a moment, read this

22 document to yourself, and then tell me when you're

23 done, please?

24 A. Okay.

00105

1 Q. This appears to be an exchange of emails

2 that you had with Dr. McCarthy, among others, at

3 Abbott in October of 2000.

4 Do you see that?

5 A. Yes, I do.

6 Q. Did you write the email that's at the

7 bottom of Exhibit 10?

8 A. I have no reason to believe I didn't.

9 Q. It's an email from you to Mr. Weiland,

10 among others. Do you see that?

11 A. Yes, I do.

12 Q. And it references -- it says, "Bob, as
13 you, Rose, and I had discussed, if we move forward
14 to set up a presentation of information to Purdue,
15 the following people could probably do the
16 presenting on key topics."

17 Do you see that?

18 A. Yes, I do.

19 Q. And there's a reference there to
20 "Preclinical ABT-594: Jim Sullivan."

21 A. Um-hmm.

22 Q. "Clinical ABT-594: Bruce McCarthy."

23 A. Um-hmm.

24 Q. "Preclinical and clinical plan ABT-963:

00106

1 George Carter."

2 A. Um-hmm.

3 Q. "Market opportunity/business rationale:
4 Andrea Landsberg."

5 Do you see that?

6 A. Yes, I do.

7 Q. Does this refresh your recollection on
8 whether there were any discussions between Abbott
9 and Purdue regarding ABT-594?

10 A. I still don't recall the meeting,
11 although I have no reason to doubt that this is
12 true.

00110

3 MR. DAVIS: Would you please mark this as the
4 next exhibit? We're up to No. 11.

5 (WHEREUPON, a certain document was
6 marked Landsberg Deposition Exhibit
7 No. 11, for identification, as of
8 2/16/07.

9 ANDREA LANDSBERG,
10 re-called as a witness herein, having been
11 previously duly sworn, was further examined and
12 testified as follows:

13 EXAMINATION (Continued)

14 BY MR. DAVIS:

15 Q. Welcome back, by the way. Ms. Landsberg,
16 you have what's been marked as Exhibit No. 11.
17 Would you look at this document for a moment and
18 please tell me if you've ever seen it before?

19 A. Not outside the context of preparing for
20 today. I don't remember it outside of the context
21 of preparing for today.

22 Q. All right. The first page appears to be
23 an email from you to Chris Silber and to
24 Ms. Waleska. Do I have that right?

00111

1 A. Yes.

2 Q. And this is for a -- some sort of
3 presentation to Dr. Jeffrey Leiden. Is that right?

4 A. Yes, it appears to be.

5 Q. What presentation is that?

6 A. I don't recall.

7 Q. Did you -- do you recall participating at
8 any point in time in any presentation to Dr. Leiden

9 regarding 594?

10 A. No.

11 Q. Did you prepare the slides that are
12 attached to Exhibit 11?

13 A. I don't recall preparing them.

14 Q. Do you believe that you prepared them?

15 A. I have no reason to doubt, looking at
16 this that I prepared them.

00116

4 Q. Would you turn, please, to the page that
5 ends in Bates number 6832? There's a slide there
6 titled "Key Product Challenges."

7 Do you see that?

8 A. Yes, I do.

9 Q. And by "key product challenges," is it
10 fair to say you meant to -- you're seeking to
11 identify particular problems that ABT-594 faced in
12 order to be commercialized successfully?

13 MR. LORENZINI: Objection; vague and ambiguous.

14 BY THE WITNESS:

15 A. I think it says just what it says. It's
16 key product challenges.

17 BY MR. DAVIS:

18 Q. What does that mean?

19 A. Challenges that we know potentially the
20 product will have and that we need to be aware of.

00118

16 Q. The first bullet point is titled
17 "Tolerability," and the subpoint says, "Competition

18 has clear advantage on tolerability."

19 How was it that the competition had a
20 clear advantage on tolerability over ABT-594 at the
21 time that these slides were prepared?

22 MR. LORENZINI: Objection.

23 BY THE WITNESS:

24 A. Yeah. Me not remembering why I wrote

00119

1 this or which -- and not looking at the prior slides
2 here to get a sense of where this falls in the
3 stack, I don't know which competition I might be
4 referring to here.

5 BY MR. DAVIS:

6 Q. As you sit here today, do you have any
7 recollection as to why it was that, on this slide,
8 you wrote, "The competition has clear advantage on
9 tolerability"?

10 A. I could speculate it was because of
11 Neurontin's known very clean tolerability. It
12 was -- we called it placebo, because it basically
13 had very little efficacy and very little side
14 effects.

00142

19 MR. DAVIS: Let's mark this as the next
20 exhibit, please.

21 (WHEREUPON, a certain document was
22 marked Landsberg Deposition Exhibit
23 No. 18, for identification, as of
24 2/16/07.)

00144

20 Q. All right. Do you recall any of the
21 email communications that are -- have been marked as
22 Exhibit 18?

23 A. No.

24 Q. The first email communication, I think,

00145

1 in time that's listed here appears to be yours,
2 dated November 29th, 2000, at 7:17 a.m., to a Larry
3 Lin, Dr. Silber, and others.

4 Do you see that?

5 A. Yes, I do.

6 Q. Who is Larry Lin?

7 A. I've been seeing his name on a lot of
8 things, and I'm still trying to place him. I'm
9 having difficulty remembering him.

10 Q. Your email --

11 A. So I --

12 Q. I'm sorry.

13 A. I don't know. I just can't remember.

14 Q. Your email under the subject says
15 "ABT-594 Forecast Scenarios for BD Partnering."

16 What is BD partnering?

17 A. Business development.

18 Q. What -- what do you recall that -- what,
19 if any, activities or communications do you recall
20 concerning business development partnering for
21 ABT-594?

22 A. I don't recall prior to seeing this. I

23 don't recall now.

24 Q. Attached to your email are some slides

00146

1 for ABT-forecast potential. Do you see that?

2 A. Yes, I do.

3 Q. Where did you obtain the information
4 contained in these slides?

5 A. I probably would have been the one to
6 develop these sales forecasts.

7 Q. Did you think that they were reasonable
8 forecasts at the time they were developed?

9 A. Yes.

10 Q. And the -- your email to Mr. Lin, among
11 others, it says at the bottom, "Larry, please let me
12 know if these numbers look acceptable. Some of them
13 may already be optimistic. BD's call as to whether
14 you want to inflate them for best case scenario."
15 What did you mean by that?

16 A. Business development might have wanted to
17 take a different look at it and increase the upside.

18 Q. And it looks like Mr. Weiland responded
19 to your email later in the day on November 29th.
20 Do you see that?

21 A. Yes, do I.

22 Q. He says, "Andrea, this looks like a
23 decent starting point. OxyContin will do over
24 1 billion by itself. I'm wondering if our upsides

00147

1 don't take us well over the \$1 billion mark."

2 Do you see that?

3 A. Yes, I do.

4 Q. At the time that these emails were
5 prepared in late 2000, did you think that ABT-594
6 had the potential to be a \$1 billion drug?

7 MR. LORENZINI: Objection to the form of the
8 question.

9 BY THE WITNESS:

10 A. I can only look to what are the forecasts
11 here and say that with the development plan, it
12 looks like I did.

13 BY MR. DAVIS:

14 Q. And, again, I take it at the time that
15 you were preparing these, you were trying to be as
16 accurate as you could. Correct?

17 A. Absolutely. These are fairly precise
18 numbers.

19 MR. DAVIS: Let's mark this, please, as the
20 next exhibit. We're up to 19.

21 (WHEREUPON, a certain document was
22 marked Landsberg Deposition Exhibit
23 No. 19, for identification, as of
24 2/16/07.)

00148

1 BY MR. DAVIS:

2 Q. Would you read this document to yourself,
3 Ms. Landsberg, and please tell me when you're done?

4 A. Okay.

5 Q. Now, this appears to be an email from a

6 Jennifer Dart to you, among others, at Abbott.

7 Do you see that?

8 A. Yes.

9 Q. Who is Jennifer Dart?

10 A. I remember a Jenny Dart and can picture
11 her. I'm not remembering which group she worked
12 with. It looks -- yeah, I don't know.

13 Q. As you --

14 A. DSG maybe.

15 Q. I'm sorry.

16 A. DSG maybe.

17 Q. As you sit here today, Ms. Landsberg, do
18 you have reason to believe that you did not receive
19 this email in or about December of 2000?

20 A. No, I do not.

21 Q. The email subject is "Analgesia Internal
22 Review Notes." And the first line says, "Thanks to
23 everyone for your participation in the analgesia
24 internal review."

00149

1 What was that?

2 A. I don't recall.

3 Q. It goes on to state, "Andrea, Laura, or
4 Chris, will one of you please set up some time with
5 Rock to review the project assumptions and
6 forecasts?"

7 What does that refer to?

8 A. What does which part of it refer to?

9 Q. Well, it says -- any of it. It says,

10 "Will you please set up some time with Rock to
11 review the project assumptions and forecasts."

12 What project assumptions and forecasts
13 are referred to there?

14 A. I don't recall what this was, so I don't
15 know which project she's referring to.

16 Q. Further on down in the same email, it
17 says, "Following is the list of follow-up items from
18 the meeting. ABT-594, Andrea will reduce forecast
19 to reflect vomiting AE."

20 Do you see that?

21 A. Yes, I do.

22 Q. Why was it that you were reducing
23 forecasts at that point in time to reflect vomiting
24 adverse offense -- events associated with ABT-594?

00150

1 MR. LORENZINI: Objection to the form of the
2 question.

3 BY THE WITNESS:

4 A. I don't recall.

5 BY MR. DAVIS:

6 Q. Do you recall, in fact, reducing some
7 forecasts associated with ABT-594 to reflect adverse
8 events of vomiting?

9 A. No, I don't recall that.

10 Q. Do you have any recollection of what
11 forecasts are referred to in this email?

12 A. The forecast is the forecast. I don't
13 know what that would mean, what forecasts? The 594

14 forecast, the 089 forecast, the Hydrocodone
15 forecast.

16 Q. Well, this one is under ABT-594. Do you
17 see that?

18 A. Yes.

19 Q. Okay. So is that --

20 A. So it looks like it would be the ABT-594
21 forecast.

22 Q. Is that the sales forecast?

23 A. You don't distinguish the sales or the --
24 you know, the product. Sometimes you show your

00151

1 forecast in sales. Sometimes you show your forecast
2 in units --

3 Q. Um-hmm.

4 A. -- volume, you know. Product -- number
5 of pills. So forecast could mean either one of
6 those.

7 Q. As -- as you sit here today, do you have
8 any recollection of ever adjusting your forecast for
9 ABT-594 to reflect adverse events of vomiting?

10 A. Not -- no.

11 Q. Do you have a --

12 A. I recall we -- we always -- you always
13 adjusted your forecasts over time. That was our
14 job.

15 Q. Um-hmm. My question is a little bit
16 different.

17 A. I know.

18 Q. My question is --

19 A. That's why I'm saying I don't recall
20 that -- that -- I don't recall that.

21 Q. Do you recall why it was necessary at any
22 point in time to adjust your forecast to reflect
23 adverse events involving vomiting?

24 MR. LORENZINI: Objection to the form of the

00152

1 question.

2 BY THE WITNESS:

3 A. Why it would be necessary?

4 BY MR. DAVIS:

5 Q. Um-hmm.

6 A. If you had -- you know, just like
7 anything, any time you have information -- no, I
8 don't understand why necessary.

9 Q. I'm sorry?

10 A. I'm -- I'm not understanding the way that
11 question is phrased.

12 Q. Well, it appears from this email that you
13 were going to reduce some forecast information
14 associated with ABT-594 --

15 A. Yes.

16 Q. -- to reflect vomiting adverse events.

17 A. Um-hmm.

18 Q. And my question is, you don't -- do you
19 have any recollection as to why that was so or why
20 you were going to do that in that time frame?

21 A. No, I don't even remember this happening,

22 this meeting.

00180

11 (WHEREUPON, a certain document was
12 marked Landsberg Deposition Exhibit
13 No. 26, for identification, as of
14 2/16/07.)

15 BY MR. DAVIS:

16 Q. Ms. Landsberg, you have what has been
17 marked as Exhibit 26. Would you look at this
18 document for a moment --

19 A. Um-hmm.

20 Q. -- and tell me if you recognize it?

21 A. No.

22 Q. It appears in the first page to be an
23 email from you to Tom Woidat, with a cc to Michael
24 Biarnesen, regarding "financial slides for Leiden

00181

1 meeting, 2/2."

2 Do you see that?

3 A. I do.

4 Q. Did you prepare the slides that are
5 attached?

6 A. I have no reason to believe I did not.

7 Q. Do you recall doing so?

8 A. No.

9 Q. The first slide deals with ABT-594 global
10 forecast ranges.

11 Do you see that?

12 A. Yes.

13 Q. Where did you get global forecast data
14 for ABT-594?

15 A. I'm assuming the global refers to the
16 fact that there's US and Ex-US down below.

17 Q. Um-hmm.

18 A. So the US ones -- the US ones would have
19 been developed by me at this point in time, it
20 seems, and the Ex-US, I think it was still Laura.
21 So ...

00183

22 Q. Were these numbers, to the best of your
23 knowledge, accurate as of the time that these slides
24 were prepared?

00184

1 A. I would have to believe I -- I thought
2 so, yes.

3 Q. The -- the next slide simply adds
4 additional information regarding NPV. Is that
5 right?

6 A. Yes.

7 Q. "NPV" being net present value?

8 A. Correct.

00189

2 Q. Ms. Landsberg, you have what's been
3 marked as Exhibit 28 for your deposition. Would you
4 look at this document for a moment and tell me if
5 you can identify it for me?

6 A. If I can identify it for you?

7 Q. Yes.

8 MR. LORENZINI: Other than what's on the title
9 page?

10 BY MR. DAVIS:

11 Q. Yes. Do you -- do you recognize it?

12 A. Not outside preparation for this meeting.

13 Q. I'm sorry?

14 A. And even then I'm not sure.

15 Q. Would you look, please, at the pages
16 that -- Bates stamped in the lower right-hand corner
17 ends in 2435, please?

18 A. 2435?

19 Q. Yes.

20 A. Yes.

21 Q. Okay. Do you see that there's a titled
22 slide there that says "ABT-594 Project Review"?

23 A. Yes.

24 Q. "February 2, 2001, Commercial Assessment

00190

1 Andrea Landsberg, Laura Robinson."

2 Do you see that?

3 A. Yes, I do.

4 Q. Do you recall making any joint
5 presentations with Ms. Robinson on ABT-594?

6 A. No.

7 Q. If you'd look, please, at the slides in
8 this section of the presentation, the commercial
9 assessment section, are those slides that you
10 prepared or helped to prepare?

11 A. I don't recall preparing them. I have no

12 reason to doubt that I might have. It looks like my
13 name on it.

00194

17 Q. Would you look, please, at the page
18 that's numbered Bates stamp ends in 2452? It's
19 titled "Key Product Challenges."

20 A. Um-hmm.

00196

4 Q. The next sub-bullet point says, "Will
5 need to minimize early DCs as much as possible.

6 What are DCs?

7 A. Probably standing for discontinuation.

8 Q. What do you -- what did you mean when you
9 said "Will need to minimize early discontinuations
10 as much as possible"?

11 A. If you're launching a product and you
12 have physicians using a product -- a new product for
13 the first time, especially one in a new class, but
14 now, in this day and age, any new product coming
15 out, their first experience with it is very
16 critical.

17 And you want to make sure you're, you
18 know, giving guidance to physicians on selecting the
19 right type of patient, using the right dosing,
20 et cetera, so that they don't experience and get a
21 negative reaction on the first patients that they
22 use it.

23 Q. And why did that present a particular
24 challenge for ABT-594?

00197

1 A. I think it presents a problem for any
2 product coming on the market.

3 Q. So these are key product challenges, not
4 for ABT-594, but for any product entering the
5 market. Is that your testimony?

6 MR. LORENZINI: Objection; argumentative.

7 BY THE WITNESS:

8 A. No, I guess here they are. You need to
9 minimize dis- -- early discontinuations in this
10 case. That's probably what we thought.

11 BY MR. DAVIS:

12 Q. Why did you think that that was a
13 particular challenge --

14 A. Because we --

15 Q. -- a key product challenge for ABT-594?

16 A. Because we knew the product had early AEs
17 in all the other clinical trials.

00202

11 Q. Ms. Landsberg, what information from the
12 114 study did you see while that study was still --
13 still under way?

14 A. I'm trying to remember if I saw any
15 information. I know we were tracking the
16 enrollment and, from what I've seen here, the
17 drop-out rates. But that's what I recall. I
18 wouldn't have recalled even that.

00203

20 Q. So the only data that you recall
21 receiving in the course of the trial was information
22 about enrollment and drop-out rates.

23 A. And if it hadn't been for what I've seen
24 here, I think I probably would have just remembered

00204

1 that chart on the wall tracking the patients.

2 Q. What is that chart on the wall that you
3 recall?

4 A. It was -- it was a -- you know, a chart
5 that had the time line and patients. And they would
6 update it kind of every day on how many patients
7 were in the trial.

8 Q. I --

9 A. That I can specifically remember, because
10 I -- I used to walk by it.

11 Q. Where -- where did you walk by it?

12 A. That was over in the -- the venture area.
13 I think it was like right outside of Chris Silber's
14 office, and there was a conference room there.
15 So -- Mike was there. I mean, they were all there,
16 so -- "they" meaning, you know, Mike and -- and
17 Bruce and Chris, where their offices were.

18 Q. How big was the chart?

19 A. Oh, I don't know. I don't think it was
20 very big. It was like a poster size -- you know, a
21 poster board, a poster size, like that, if you can
22 estimate that, four-by-three or something

23 (indicating).

24 Q. And you recall the chart was updated

00205

1 periodically?

2 A. Yes.

3 Q. Who was updating the chart?

4 A. I wouldn't have been able to say. I'm
5 wondering if it was Marilyn Collicott or -- I
6 just -- I think she -- it seems like she was the
7 CRA, and that would be who would normally be
8 updating those chart.

9 Q. What color was the chart?

10 A. I haven't the faintest. That I don't
11 remember.

12 Q. Do you recall what the chart was titled?

13 A. No.

14 Q. And was it the same chart that someone
15 was manually updating, or was it a new printout of a
16 chart?

17 A. I don't remember that, either.

18 Q. What kind of material was the chart on?

19 A. I think it was paper or I think it was
20 like a poster board.

21 Q. What ultimately happened to the chart?

22 A. I haven't the faintest idea.

23 Q. And you said it was in the venture office
24 or the venture area?

00206

1 A. Venture area.

2 Q. What was the venture area?

3 A. As I was saying, just where Chris
4 Silber's offices were there, those people who were
5 in that venture were sitting.

6 Q. Was that where Dr. McCarthy's office was
7 located --

8 A. Yes.

9 Q. -- as best recall?
10 Can you identify any other people who you
11 remember having offices in that area?

12 A. Mike Biarnesen. Those are the three
13 offices I remember right there in that area.

14 Q. Approximately over what period of time do
15 you recall seeing that chart?

16 A. I -- I don't know.

17 Q. It was while you were working on ABT-594?

18 A. Yes. That's the only time I would have
19 been over in that building. I don't even remember
20 which building it was. I think it was AP 34.

Landsberg Dep. Ex. 4 / PLs' SL



Andrea
Landsberg /LAKE/PPD/ABBO
TT
08/07/2000 05:54 PM

To Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT
cc Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Michael K Biarnesen/LAKE/PPRD/ABBOTT@ABBOTT
bcc
Subject 594 development plan

Bruce,
I am forwarding this latest version to you as I was planning on having it all done today but got sidetracked helping Rose with a fire drill for Arthur for 4 hours this afternoon (NO LIE!!). As you can see, however, I am nearly done with the (very) notable exception of the product labeling piece. I also want to do a little more research into pricing and the managed care strategy to finalize those sections and I have a few more numbers to insert into the forecast chart -- but aside from that its just about there!!

I would like to set up a meeting to review this with you at the least, or you and Laura and whoever you think would be appropriate -- I think some of this content should be discussed and agreed upon rather than put forward by me unilaterally. (Unless I really am being foolish in thinking anyone will ever read this.....). Let me know what you think.

Thanks!
Andrea



594 development plan - commercial sections

Landsberg DEP. EX. NO. 4
FOR ID., AS OF 3-16-07 BC

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ABBT0109806

B. Marketplace: Chronic Neuropathic and Nociceptive Pain**B.1 a Neuropathic Pain Marketplace SWOT Analysis**

Table B.1a includes a summary of the strengths, weaknesses, opportunities and threats associated with the information presented in this section with respect to the development of ABT-594.:

Table B.1a SWOT Analysis (Strengths/Weaknesses/Opportunities/Threats)		
CATEGORY	ITEM (Impact)	STRATEGY
Strengths	Increasing incidence of diabetes and subsequent diabetic neuropathy market (Mod) Indication in diabetic neuropathy will likely lead to some spillover use in other neuropathic pain and chronic nociceptive pain (High) Bulk of competition is generic (Mod) Few products have indication for neuropathic pain limiting sales and marketing efforts (High)	Conduct or fund trials in neuropathic and chronic nociceptive pain beyond diabetic neuropathy Obtain indication for neuropathic pain (as broadly as possible) Capitalize on indication labeling through appropriate sales and marketing campaign
Weaknesses	Current leading treatment (gabapentin) perceived as effective, safe and well tolerated (High) Advances in the treatment of glycemic control could decrease the rate at which diabetic neuropathy occurs (Low in near term) Diabetic and other neuropathies are often underdiagnosed and mis/under-treated (Mod) Painful aspect of neuropathy is not always present or persistent (Mod) Limited regulatory history for indication (Mod)	Conduct trials to compare efficacy and tolerability to market leaders Monitor competitive landscape and adjust clinical development and marketing strategies appropriately Support screening and aggressive treatment of diabetic and other neuropathies Work closely with regulatory and plan for 'End of Phase II' FDA meeting
Opportunities	Large unmet need for effective treatments (High) Novel mechanism may generate increased excitement (Low) Increasing focus on aggressive treatment of pain (Mod)	Demonstrate equal or better efficacy to currently available agents Demonstrate equal or better tolerability to currently available agents
Threats	Gabapentin follow-on compound, pregabalin, may be even more effective and may pursue indication for neuropathic pain (High) Pricing pressure from managed care, government due to shift from low cost generics (Mod) Nicotinic association could decrease public acceptance and raise fears regarding addictive potential (Mod) Primary treatment aimed at neuropathic process could limit market for neuropathic pain agent (Low)	Maximize efficacy, safety and convenience of compound and formulation Conduct pharmacoeconomic studies and garner support of patient advocacy groups Develop and execute public relations plan to allay fears regarding nicotine Conduct studies to demonstrate non-addictive nature of compound

Version 1, revised 7/31/2000chk...mr development plan/2000-revised July

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ABBT0109807

B.1 b Chronic Nociceptive Pain Marketplace SWOT Analysis

Table B.1b includes a summary of the strengths, weaknesses, opportunities and threats associated with the information presented in this section with respect to the development of ABT- 594.:

Table B.1b SWOT Analysis (Strengths/Weaknesses/Opportunities/Threats)		
CATEGORY	ITEM (Impact)	STRATEGY
Strengths	<p>Large, growing market consisting of primarily OA, RA and back pain (High)</p> <p>Large undiagnosed OA population to provide significant market growth (Mod)</p> <p>Increasing incidence of chronic pain conditions with aging population (Mod)</p> <p>Over 50% of chronic pain patients take a medication every day (Low)</p>	<p>Conduct trials in OA or other chronic nociceptive pain area for indication or publication</p> <p>Support screening and increased treatment of OA</p>
Weaknesses	<p>Competitors may not require titration to avoid AEs and therefore can be used PRN rather than limited to only those patients on persistent, daily therapy (Mod)</p>	<p>Work on formulation to minimize or eliminate need for titration</p>
Opportunities	<p>Significant unmet need for alternative to opioids that have equal efficacy with less side effects and no scheduling (High)</p> <p>"Ceiling effect" of NSAIDs and COX 2 competitors (Mod)</p>	<p>Conduct opioid sparing or opioid replacement trials</p> <p>Conduct studies to demonstrate non-addictive nature of compound</p> <p>Position 594 as 'bridging' compound after ceiling effect reached and before use of scheduled narcotics</p>
Threats	<p>COX -2s may be firmly entrenched as market leaders for all chronic pain conditions (Mod)</p> <p>Combination products combining opioids with non-opioid analgesics or potentiators may meet market demand for improved side effect profile and offer steep competition (Mod)</p>	<p>Demonstrate key benefits over current and potential competitors in terms of efficacy or safety</p> <p>Carefully position along pain severity spectrum to preserve a target patient population</p>

B.2 Epidemiology/Disease Class

Pain is the most common symptom of disease and the most frequent complaint with which patients present to physicians. The economic burden of pain in the United States is estimated at \$100 billion a year in direct and indirect costs. Approximately 95 million Americans per year receive drug therapy for pain, which represents about 50% of those who suffer from pain. (more

appropriate below in market overview) Chronic pain, including both neuropathic and nociceptive pain, is considered to be the single most common cause of suffering and disability in the industrialized world with an estimated 25-30% of the population experiencing some form of chronic pain. Chronic neuropathic pain is a frequent sequelae (sp?) of diabetes, AIDS, and other viral infections, as well as 'entrapment' disorders such as carpal tunnel syndrome. Diabetes is increasing at an alarming rate in the United States, with an estimated 15 million type II diabetics in 2000, and, despite advances in treatment, the development of complications such as neuropathy remains significant. The diagnosed prevalence of diabetic neuropathy is estimated to be about 2 to 3 million patients, with at least 10 to 20% of those patients experiencing painful symptoms.

Chronic nociceptive pain categories include osteoarthritis, chronic back and neck pain, rheumatoid arthritis, and cancer pain and these diagnoses are expected to become more prevalent as the population ages. Current overall prevalence for these disorders is staggering, over 200 million worldwide, and, although the diagnosed and treated populations are lower, improved treatment options and awareness have the potential to drive significant growth. Osteoarthritis (OA) is one of the largest segments of the analgesia market, and one of the most common nociceptive pain conditions treated by primary care physicians and Over 35 million people worldwide suffer from OA, and three-fourths of OA sufferers surveyed indicate that the disease interferes with their daily activities. Estimates of worldwide sales of prescription analgesics to treat OA range from \$2.25-3 billion. According to a recent study, as many as 47% of Americans diagnosed with OA take a prescription analgesic at least occasionally for the condition. NSAIDs/COX-2s and acetaminophen are the standard treatments for OA. However, the new COX-2 inhibitors are expected to grow the OA market due to their expected higher levels of GI safety. This added safety would attract patients who were administered prescription or OTC NSAIDs only occasionally to avoid potentially severe gastric ulcerations and bleeding. The COX-2 inhibitors will also take share from branded and multisource prescription NSAIDs. As a result, the COX-2 inhibitors are expected to grow the OA market in prescriptions and sales, maybe by a significant amount.

A summary of the prevalence of relevant chronic pain diagnoses is shown in Table B.2c.

Table B.2c Prevalence of Key Target Pain Diagnoses		
Diagnosis	Est. 2000 Prevalence (MM)	
	U.S.	Worldwide ³
Neuropathic Pain in Diabetic Neuropathy ¹	0.6	0.9
Postherpetic and Trigeminal Neuralgia ¹	0.5	0.7
Osteoarthritis ²	9.4	24.3
Chronic Low Back Pain ²	8.5	21.6
Rheumatoid Arthritis ²	1.9	2.9
Cancer Pain ²	1.0	1.2
Total for Key Pain Diagnoses	21.9	51.6
1. Decision Resources, 1999. Data reflect number of pain diagnoses such that a patient might be diagnosed with two pain diagnoses of different pain types at separate visits. 2. Decision Resources, 1999 (Data presented reflects <i>diagnosed</i> prevalence) 3. Germany, France, Italy, Spain, UK, and Japan.		

B.3 Market Overview [Andrea/Laura to review]

Pain is the most common symptom for which individuals seek medical assistance. Pain is the primary complaint of 50% of all patients who visit a physician.

The economic burden of pain in the United States is estimated to be \$100 billion a year in direct and indirect costs. In 1996, the worldwide diagnosed pain population was 427 million, of whom 37% were from the U.S. and 63% from outside the U.S. Approximately 95 million Americans per year receive drug therapy for pain, which represents only about 50% of those who suffer from pain. Physician or patient concern about drug safety and side effect profiles, fear of addiction, the use of OTC therapies, or non-pharmacological treatments account for the 30-50% of patients who seek treatment for pain but are not prescribed an analgesic. Efforts to change this mindset, however, are likely to result in a greater percentage of sufferers receiving pharmacologic therapy. Pain specialists, advocacy groups and patients have campaigned vociferously for the more aggressive treatment of pain over the last decade. One trend toward acceptance of this standard is the 12% increase over prior year in 1999 sales of injectable narcotic agents. While much of the

effort has targeted physician and patient fears of opioid use, the primary goal is to treat pain more proactively and completely. (the above was the only example I could find) The great success of the recently launched COX-2 analgesics, achieved by growing the market with minimal erosion of the NSAID class, speaks to the increasing consciousness regarding pain management and the high unmet need for drugs that are safer, yet maintain equivalent efficacy, than those currently available. It is expected that, as improved treatments become available and awareness of the long term benefits of adequate pain management becomes widespread, the pain market will grow considerably. ~~Total U.S. sales of prescription pain medications reached over \$5.1 billion in 1998.~~

Chronic pain sufferers may account for as much as 20% of the adult population implying over 130 million adults in the seven major pharmaceutical markets suffer from chronic pain. It is estimated that only one-fourth to one-half of chronic pain patients obtain inadequate pain relief. The chronic pain market can be segmented into two major groupings, neuropathic and nociceptive. ~~Over the near term, the pain market is likely to grow. [Andrea to provide evidence of market growth in recent past and expectations for future]. The pain market can be segmented along several lines. A major division is between neuropathic and nociceptive pain.~~ Chronic neuropathic pain includes the pain associated with diabetic polyneuropathy, post-herpetic neuralgia, sciatica, entrapment neuropathies (such as carpal tunnel syndrome), phantom-limb syndrome, and others. Chronic nociceptive pain includes pain associated with surgery, trauma, osteoarthritis, rheumatoid arthritis, lumbar spine disease, cancer, and other causes. Neuropathic and nociceptive pain differ in symptoms, pathophysiology and treatments.

Neuropathic pain is a large, yet largely untapped market. Estimates vary widely for the number of worldwide sufferers, from as low as 20 million to as high as 50 million or more. Estimates of the number of cases is limited by inadequate epidemiological studies. One report puts the total US prevalence of neuropathic pain at 4 million. Neuropathic pain is often treated with tricyclic antidepressants (TCAs), anticonvulsants (e.g. gabapentin) and alpha adrenergic agonists; collectively, these drug classes are sometimes referred to as "adjuvant pain medications". PCPs often still prescribe OTC analgesics or prescription NSAIDs for neuropathic pain even though there is little evidence for their usefulness in for this condition. US sales in 1999 for the key neuropathic pain treatments, Neurontin, carbamazepine, and tricyclic antidepressants (TCAs), are estimated to be \$350 million. This dollar market value likely underestimates this market's potential due to a number of factors. Only the anticonvulsant Tegretol (carbamazepine), which is off-patent, has a specific indication for neuropathic pain in the US (although Neurontin (gabapentin) recently received an indication in the UK for the treatment of neuropathic pain). Therefore there has been no funding from the pharmaceutical industry to improve diagnosis and

treatment of neuropathic pain and drive market growth. Of even greater impact on total market sales, most of the agents used to treat this population, with this exception of Neurontin, are low cost, generic products. ~~Prescription drug sales for the treatment of neuropathic pain exceed \$1 billion worldwide~~ (Bruce: where did this come from? I cannot find anything to justify this number from the data and reports I have but am happy to go with it if we have a recent reference). In the U.S. alone, approximately \$250 million of the sales of the anticonvulsant Neurontin (gabapentin) are attributed to off label use for the treatment of neuropathic pain. A

Significant unmet need remains, however, in the treatment of neuropathic pain since few medications provide complete pain relief and most adjuvant medications have significant side effects. As the prevalence of the underlying disorders (diabetes, herpes zoster, etc) increases with the aging population and more effective and tolerable medications become available, the neuropathic pain market is expected has the potential to experience significant growth. The following tables show the factored U.S. and ex-U.S. prescription and sales volume for key neuropathic pain therapies 1999.

Table B.3a. 1999 Key Neuropathic Pain Products, Estimated TRxs				
Class	1999 U.S. TRx (MM)	U.S. TRx CAGR '97-'99	1999 ex-U.S. TRx (MM)	ex-U.S. TRx CAGR '97-'99
Neurontin	3.3	26.3%	N/A	N/A
Carbamazapine	1.0	12.6%	N/A	N/A
TCAs	8.2	1.1%	N/A	N/A
TOTAL	12.5	5.6%	N/A	N/A
Source: IMS, factored for neuropathic uses. N/A = not available				

Table B.3b. 1999 Key Neuropathic Pain Products, Estimated \$ Sales				
Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR '97-'99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR '97-'99
Neurontin	\$308	28.7%	N/A	N/A
Carbamazapine	\$17	13.1%	N/A	N/A
TCAs	\$26	-3.3%	N/A	N/A
TOTAL	\$351	21.7%	N/A	N/A

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Source: IMS, factored for neuropathic uses; Ex-U.S. data includes retail pharmacy data from all audited markets and hospital data from major European markets and Canada only.

Nociceptive pain is categorized by duration (acute or chronic) and by severity (mild, moderate, and severe). The mild and, to a lesser extent, moderate segments have multiple product entries and are generally well satisfied by OTC products such as aspirin, acetaminophen, ibuprofen and other NSAIDs/COX-2s. Prescription NSAIDs are generally written for chronic pain of moderate severity, though potentially serious GI or renal side effects may complicate treatment (COX-2s may be associated with fewer adverse events). The moderate and severe segments of the market have many opioid product offerings that are mostly generic, undifferentiated and inexpensive. Some branded opioids, however, have been very successful (OxyContin is projected to have 2000 revenues of \$1 billion). Many patients, however, develop tolerance to these drugs. In addition, opioids are scheduled, a regulatory status that creates administrative burdens and barriers to prescribing. These barriers are particularly high in European markets. As a result, opioid use in Europe is restricted almost entirely to cancer pain and there exists a large unmet need for effective treatment of severe pain. While opioids and combination opioids accounted for the majority of analgesic prescriptions at 55%, NSAIDs had the highest share of total prescription analgesic sales at 37%.

~~{the following section has been updated to reflect the new organization of this section into neuropathic and nociceptive pain, but the market segmentation parallels to the IMS data must be verified and updated...i.e., originally, this section was a discussion of the three classes of analgesics without reference to nociceptive per se}~~

The prescription market for nociceptive pain is made up of ~~at least three~~ four key classes of analgesics: NSAIDs, COX-2s, Opioids (and combination products), and Other Non-Opioids (including aspirin, acetaminophen, and synthetic non-opioids). ~~Anesthetics, anti-migraine and adjuvant medications are not included in this market definition.~~ The following tables show U.S. and ex-U.S. prescription and sales volume for key pain classes for 1999.

Table B.3c. 1999 Key Prescription Nociceptive Pain Products, TRxs				
Class	1999 U.S. TRx (MM)	U.S. TRx CAGR '97-'99	1999 Ex-U.S. TRx (MM)	Ex-U.S. TRx CAGR '97-'99
NSAIDs	70.7	-1.4%	N/A	N/A

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COX-2s	22.4	N/A	N/A	N/A
Opioids ¹	154.2	2.5%		
Other Non-Opioids ²	45.5	-0.9%	N/A	N/A
TOTAL	292.8	0.8%	N/A	N/A
Source: IMS N/A = not available or not applicable ¹ Includes IMS groups: Morphine, codeine and combos, propoxyphene, synthetic narcotics (injectable and non-injectable) ² Includes IMS groups: Synthetic non-narcotics, aspirin, acetaminophen (injectable and non-injectable)				

Table B.3d. 1999 Key Prescription Nociceptive Pain Products, \$ Sales

Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR '97-'99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR '97-'99
NSAIDs	\$1,565	-3.2%		
COX-2s	\$1,558	N/A		
Opioids ¹	\$1,887	7.7%		
Other Non-Opioids ²	\$1,337	-4.5%		
TOTAL	\$6,347	4.3%		
Source: IMS (excludes injectables) ¹ Includes IMS groups: Morphine, codeine and combos, propoxyphene, synthetic narcotics (injectable and non-injectable) ² Includes IMS groups: Synthetic non-narcotics, aspirin, acetaminophen (injectable and non-injectable) Ex-U.S. data includes retail pharmacy data from all audited markets and hospital data from major European markets and Canada only.				

NSAIDs and COX-2s are generally used in chronic nociceptive pain syndromes and when pain severity is of mild to moderate intensity. NSAIDs/COX-2s exhibit analgesic and mild anti-inflammatory properties, and are drugs-of-choice in such pain conditions as osteoarthritis, rheumatoid arthritis and lower back pain. NSAIDs/COX-2s have fewer central nervous system side effects than opioids. NSAIDs, however, can cause potentially serious renal and gastrointestinal side effects, including gastric ulceration and bleeding. COX-2s may appear to have a lower rate of these adverse events, due to increased selectivity of action. However, current COX-2s do not eliminate the risk of GI complications completely. ~~but experience with COX-2 is limited to the past year.~~ Another drawback of NSAIDs/COX-2s is the presence of a

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'ceiling effect' in which even additional amounts of drug fail to increase analgesic activity. This factor often leads to the use of stronger analgesics such as opioids.

(reordered) In the U.S., opioid analgesics are considered the drugs-of-choice for acute nociceptive pain, especially of moderately-severe to severe intensity. Physicians often avoid prescribing opioids for chronic pain conditions due to fear of tolerance and addiction, although opioids are the most commonly prescribed medication for moderate to severe cancer pain. Ex-U.S. opioid use varies considerably by country. Physicians in Scandinavia, the UK, France and [Japan-verify] are more likely to prescribe opioids compared to other ex-U.S. countries and prescriptions have increased considerably over the past 5 years. In Italy, Spain and Germany, opioid use is extremely restricted, requiring patient identity cards and special prescription forms that must be obtained, in person, by the physician; morphine is often considered a last resort. In both the U.S. and ex-U.S., opioids are government-scheduled products with restricted prescribing and product distribution.

~~"Other non-opioids"~~ Non-narcotics include ~~are defined as~~ (1) non-opioid/non-NSAID agents like aspirin, acetaminophen or tramadol, and (2) NSAIDs that are positioned and marketed as analgesics, such as ketorolac or bromfenac sodium. These non-narcotics are generally used in place of opioids to treat moderate pain, or in some cases, moderately-severe pain.

Most analgesics are indicated for the treatment of one or more specific nociceptive pain states (e.g. osteoarthritis). Depending on its characteristics, however, a significant number of a product's prescriptions may come from non-indicated pain states (i.e., spillover prescriptions). A product indicated for osteoarthritis, for example, is likely to be prescribed for chronic lower back pain, rheumatoid arthritis, and other pain states with similar clinical characteristics or etiologies. Efficacy in osteoarthritis has become a benchmark for analgesic efficacy in most chronic nociceptive pain states of mild to moderately severe intensity.

B.4 Current Treatment Options

TABLE B.4A CURRENT TREATMENT OPTIONS: NEUROPATHIC PAIN				
Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Antiepileptics as analgesics*	Gabapentinoids (gabapentin)	Unknown	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Effective, well tolerated, not metabolized, no drug interactions <u>Side effects:</u> Dizziness at high doses <u>Other drawbacks:</u> No neuropathic claim in US; cost; modest analgesic effect, titration
	Iminostilbenes (carbamazepine)	Slows voltage-gated Na ⁺ channel activation recovery	Trigeminal neuralgia	<u>Strengths:</u> Very effective, inexpensive <u>Side effects:</u> Ataxia, dysmetria, unsteadiness, hepatotoxicity, aplastic anemia, hypersensitivity reactions <u>Other drawbacks:</u> Drug interactions
Antidepressants as analgesics	Tricyclic antidepressants (amitriptyline, nortriptyline)	Probably inhibit biogenic amine reuptake	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Modest analgesic effect, inexpensive <u>Side effects:</u> Anti-cholinergic (dry mouth, sedation), cardiac arrhythmia, weight gain <u>Other drawbacks:</u> Cardiac effects, titration
	Mixed serotonin and norepinephrine reuptake inhibitors (venlafaxine)	Mixed serotonin and norepinephrine reuptake inhibitors (venlafaxine)	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Modest analgesic effect, inexpensive? <u>Side effects:</u> Anti-cholinergic (dry mouth, sedation), cardiac arrhythmia <u>Other drawbacks:</u> Cardiac effects, titration
Miscellaneous	Opioid and norepinephrine reuptake inhibitor (tramadol)	Opioid and norepinephrine reuptake inhibitor	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Moderate pain relief without the opiate stigma, non-scheduled <u>Side effects:</u> Nausea, vomiting, sedation <u>Other drawbacks:</u> May reinstate physical dependence in previously opioid-dependent patients. May eventually receive scheduled status

* Many newer antiepileptic agents (e.g., Tiagabine, lamotrigine) have recently or will soon undergo clinical trials in neuropathic pain.

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TABLE B.4B CURRENT TREATMENT OPTIONS: NOCICEPTIVE PAIN				
Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Opioid	Opioids (e.g., morphine, codeine)	Opioid receptor activation	Surgery, injuries, musculoskeletal disorders, cancer Moderate to severe pain Opioids are the drugs of choice for severe acute pain and cancer pain	<u>Strengths:</u> Potent analgesic effect, inexpensive <u>Side effects:</u> Constipation, Nausea and Vomiting, Sedation, Cognitive Impairment, Respiratory Depression, Pruritis <u>Other drawbacks:</u> Development of tolerance, addiction potential, scheduled drugs, do not reduce inflammation
	Opioid Combination with another analgesic (e.g., aspirin or acetaminophen)	Opioid receptor activation Combination preparation offsets opioid side effects by adding second analgesic with a different mechanism of action	Surgery, injuries, musculoskeletal disorders Moderate to severe pain	<u>Strengths:</u> Potent analgesic effect, and depending on combination agent, may also decrease inflammation and body temperature; reduced opioid side effects <u>Side effects:</u> All effects associated with each of the drugs administered, although reduced in frequency and severity <u>Other drawbacks:</u> All drawbacks associated with each of the drugs administered
Non-Opioid	NSAIDS	Inhibit the synthesis of prostaglandins, which are responsible for inflammation, increased body temperature, and sensitization of pain receptors	Osteoarthritis, rheumatoid arthritis, lower back pain, and other chronic pain conditions in addition to some mild to moderate acute pain conditions	<u>Strengths:</u> Fewer CNS side effects than opioids, and no addiction potential, inexpensive <u>Side effects:</u> Gastric ulceration and bleeding <u>Other drawbacks:</u> Ceiling effect (complete pain relief cannot be achieved even after dose escalation)

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TABLE B.4B CURRENT TREATMENT OPTIONS: NOCICEPTIVE PAIN				
Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Non-Opioid (con't.)	COX-2 Inhibitors (celecoxib)	Inhibit the synthesis of prostaglandins, which are responsible for inflammation, increased body temperature, and sensitization of pain receptors Preferential COX-2 vs. COX-1 inhibition may reduce risk of GI interaction		<u>Strengths:</u> Claim fewer GI side effects than NSAIDs with similar analgesic effect <u>Side effects:</u> Peripheral edema <u>Other drawbacks:</u> cost
	Acetaminophen	Mechanism of action is poorly understood, but appears to involve effects in the CNS (has analgesic and antipyretic effects)	Sprains, strains, injuries, musculoskeletal pain, osteoarthritis Management of mild to moderate pain	<u>Strengths:</u> Has no effects on platelet function, has no GI toxicity, has fewer CNS side effects than do opioids, inexpensive <u>Side effects:</u> May be hepatotoxic in heavy drinkers and patients with liver disease <u>Other drawbacks:</u> Lacks anti-inflammatory activity. Ceiling effect (complete pain relief cannot be achieved even after dose escalation)
Miscellaneous	Opioid and norepinephrine reuptake inhibitor (tramadol)	Dual mechanism of action via opioid and non-opioid mechanisms (norepinephrine reuptake inhibitor)	Used in the treatment of moderate to severe pain	<u>Strengths:</u> Moderate pain relief without the opiate stigma, non-scheduled <u>Side effects:</u> Nausea, vomiting, sedation <u>Other drawbacks:</u> May reinstate physical dependence in previously opioid-dependent patients. May eventually receive scheduled status

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B.5 Competitive Analysis -- Emerging Competition [Andrea/Laura to review]

Almost 100 compounds are currently in development for prescription pain management, though some of these compounds are also being developed for other non-analgesic indications. The majority of the analgesic compounds in the pipeline represent incremental improvements to the opioids or NSAIDs, or consist of new formulations or delivery mechanisms for the standard analgesics. Fewer than 30% of the compounds in development have novel mechanisms of action. Drugs with novel mechanisms are expected to provide the bulk of the promoted competition for ABT-594.

Among the novel agents in development, the greatest threat to ABT-594 is likely to be posed by other nicotinic compounds in development for pain. ABT-594, now in Phase IIb trials, is suspected to be the most advanced nicotinic compound in the analgesia pipeline. The first nicotinic compounds from competitors to be launched in the class may be for Alzheimer's Disease or Parkinson's Disease. These compounds do not represent a threat to ABT-594, unless significant safety concerns or evidence of tolerance, dependence or abuse are an issue and become associated with the class as a whole.

The pipeline for the treatment of neuropathic pain does not have a blockbuster compound on the order of the COX-2 inhibitors. However, pregabalin, the follow-up to Parke-Davis' Neurontin (gabapentin), is expected to perform well; analyst reports predict its sales for neuropathic pain may be almost \$100 million by 2003, its second year post expected launch. Initial data from pregabalin suggests a compound that overcomes the absorption and uptake limitations associated with gabapentin leading to a more convenient dosing schedule and resolved 'ceiling effect'. However, increased doses and corresponding increased plasma levels appear to be associated with greater efficacy and more frequent adverse events. The marketing and sales power of Pfizer is likely to drive the product to success, despite such concerns.

For the treatment of osteoarthritis (OA), the COX-2 inhibitors represent the most significant competition, with sales of as much as a staggering \$13 billion by 2004 being predicted. Use beyond pain into colorectal cancer and neurodegenerative disorders is also being explored for COX-2s. Searle and Merck both have follow-up compounds well along in development which purport to have greater selectivity for COX-2 vs. COX-1 and therefore offer the potential for increased potency and decreased side effects. Other second generation COX-2s are in the pipeline, although J&J recently announced the decision to stop development of Japan Tobacco's compound FTE 522. Unresolved side effect issues surrounding COX-2 inhibitors remain,

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however, including the risks of thrombosis, hypertension, reproductive dysfunction and teratogenicity that may show up as the exposure to these agents becomes more widespread. The launch of Searle's Celebrex (celecoxib) in January 1999 is one of the most successful product launches in industry history. After ten weeks on the market, prescriptions for Celebrex represented 24% of new NSAID prescriptions. Merck's Vioxx (rofecoxib), approved in May 1999 is also expected to be a very successful product in the treatment of OA as well as other pain states.

Table B.5a. Analgesia Pipeline -- Key Novel Agents

Product	Company	Mechanism	Phase	Comment
pregabalin	Parke-Davis	Ca channel blocker	III	Neuropathic pain, chronic pain Follow-up to Neurontin
saredutant	Sanofi	NK-2 receptor antagonist	II	General pain MOA losing favor; active program?
ZD4952	Zeneca	prostaglandin receptor antagonist	II	Moderate to severe pain
GV196771	Glaxo	glycine antagonist	II	Chronic pain, showing promise
tepoxalin	J&J	COX/5-LO inhibitor	II	OA, described as 'steroid replacing anti-inflammatory drug'
darbufelone	Parke-Davis	COX/5-LO inhibitor	II	General pain
HCT-3012	NicOx	Nitric oxide NSAID	I	Pain and inflammation
cizolirtine	Esteve	Substance P	II	Analgesia, antipyretic
Others??				

Sources: ADIS, IMS, Decision Resources, company reports

Table B.5b. Development Pipeline -- Nicotinic Mechanisms

Product	Company	Phase	Comment
GTS-21	Taiho	II	Target is Alzheimer's Disease May have preclinical pain program; looking for partner
CMI 980	Cytomed	Preclinical	Target is pain Epibatidine analog

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SIB-T1887	Sibia	Preclinical	Target is pain
FID 072021	Fidia	Preclinical	Target is pain; not actively funding
Sources: ADIS, IMS, company reports			

B.6 Unmet Needs [Andrea/Laura to review]

In general, a significant unmet need exists for safer, non-abusable, non-addicting, non-tolerance producing, and non-scheduled efficacious oral and parenteral analgesic products for the treatment of moderate to severe neuropathic and chronic nociceptive pain.

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Table B.6. Unmet Market Needs and the Impact of the Pipeline	
Unmet Need	Pipeline Impact
Efficacy in moderate to severe pain without tolerance, dependence or abuse	Novel nicotinic agents like ABT-594 may provide efficacy in more severe pain states without opioid-like liabilities
Efficacy in neuropathic pain	Pregabalin may provide incremental improvement in neuropathic pain efficacy over gabapentin, but may also have increased frequency of adverse events Novel nicotinic agents like ABT-594 appear to have efficacy in neuropathic pain, based on animal models
Reduction in the GI bleeding risk of NSAIDs	COX-2 inhibitors appear to reduce the incidence and severity of GI ulcers and bleeding; second generation COX-2s may increase therapeutic window further but Celebrex retains labeled warnings regarding ulceration comparable to traditional NSAIDs
Overcome ceiling effect of NSAIDs	Preclinical studies did not indicate a ceiling effect for novel nicotinic agents like ABT-594
Extended dosage intervals or novel delivery mechanisms for improved compliance and convenience	Once weekly dosing formulations being explored for COX-2s, etc. Patch technology improvements likely
Therapies aimed at disease modification, prevention	Agents that decrease rate of diabetic complications (eg aldose reductase inhibitors) or directly treat neuropathy (bimocimol) may decrease incidence of neuropathic pain

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C. Product Positioning

C.1 Product Positioning Options [Andrea/Laura to review]

Table C.1a includes a summary of the strengths, weaknesses, opportunities and threats associated with the information presented in this section with respect to the development of ABT-594.

Positioning alternatives/options	Strategy	Strengths	Weaknesses
Equal efficacy to Neurontin and TCAs in neuropathic pain with improved dosing, AEs, and safety	Sell against top neuropathic pain products on convenience, tolerability and safety	Efficacy to date supports BID, possibly QD dosing Low level of CNS AEs No weight gain	May have too high level of nausea and vomiting to compete with Neurontin (pregabalin?) on AEs
Better efficacy than Neurontin and TCAs with comparable dosing, AEs and safety	If AEs for ABT-594 too frequent vs. competition, sell on 'power'	Efficacy data likely to support May be better fit with AE profile	Neurontin and TCAs <i>perceived</i> to have high efficacy; may not be able to match Neurontin's perception as extremely safe and well tolerated
The only oral agent <u>indicated</u> for the treatment of neuropathic pain	Capitalize on 'government approved' status to increase prescriber confidence	Data to date supports efficacy in neuropathic pain Current timeline gives ABT-594 neuropathic pain indication by mid 2004	Pregabalin (or others?) may be to market first with neuropathic pain indication Neuropathic pain indication still uncertain from regulatory standpoint
Equal efficacy and safety to COX-2s without ceiling effect	Attempt to enter into large COX-2 market	No ceiling effect seen with ABT-594	May limit use to <i>after</i> COX-2 failure COX-2 agents will be firmly entrenched
Opioid-like efficacy without addictive potential and with fewer AEs than opioids for treatment of moderate to severe chronic pain	Capitalize on market reluctance to use opioids by providing safe, efficacious alternative	Provides clear, compelling reason to use and matches product profile to date	May niche ABT-594 to more severe patients and limit market

"General" pain	Requires data to support acute (molar extraction and post-surgical pain) and chronic claims	Would create a drug for most kinds of pain	ABT-594's analgesic onset is too delayed for acute use
Chronic pain	Requires data from chronic pain states, but pain states not currently associated with indications (not osteoarthritis, not cancer; acceptable data might include low back pain, fibromyalgia); does not include neuropathic pain	Label would support use in the wide variety of chronic pain (large population)	Regulatory paradigm untested and pain states specified represent high risk trials
Neuropathic pain	Submit data on diabetic neuropathy pain. Phase IV to extend to other neuropathic pain disorders (e.g., PHN)	Would address significant unmet needs; add smaller neuropathic segments later	Regulatory paradigm untested
Disease-specific claim—osteoarthritis	Submit or publish data in osteoarthritis to demonstrate ABT-594's efficacy in a chronic nociceptive pain state. Because osteoarthritis is a well-recognized model of pain, market research predicts significant use in other chronic nociceptive pain states based upon osteoarthritis data alone	Label would specifically support use in osteoarthritis, a large but fairly well-reviewed market. Off-label use may extend to entire chronic nociceptive market. Publication alone in osteoarthritis may provide basis for off-label use in entire nociceptive market (with subsequent publication in other chronic nociceptive pain states)	Fairly well-served market

C.2 Target Product Profile [Andrea/Laura to review]

C.2.1 ABT-594 Target Product Profile

Table C.2.1 below, outlines the desired target product profile for ABT-594:

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Table C.2.1. ABT-594 Target Profile					
PPCC/DDC Profile (12/10/97)	Current Profile (8/00)	Rationale for Profile Change	Probability	Status	Share Impact
Indicated for the treatment of pain (general pain claim)	Indicated for the treatment of osteoarthritis pain	"General pain" claim not achievable due to slow onset of action; proof of principle established in molar extraction study Indication specific claims now favored since general pain claim not achievable	Medium	9/99, 1Q01	High
Effective in neuropathic pain	Indicated for the treatment of neuropathic pain	Indication specific claims now favored since general pain claim not achievable	Low	9/99, 2Q01	Medium
Effective for moderate to moderately-severe pain	N/A	No longer applicable without general pain, acute or chronic pain (not otherwise specified) claims??	N/A	N/A	N/A
Not scheduled/no abuse potential?	No change	N/A	High	4Q02	High
Improved safety profile compared to opioids including: - less GI motility impairment - less respiratory depression - low tolerance potential - no dependence/ withdrawal	No clinically significant tolerance, dependence or withdrawal In contrast to opioids, no constipation or respiratory depression liability Tolerability comparable to currently used neuropathic and chronic nociceptive pain products	Simplify profile to focus on the most commercially important ABs Need to be well-tolerated to sell in crowded market with many alternatives	Medium	2Q01	High
	Very few abnormal LFTs	Abnormal LFTs in a few Phase I subjects	High	9/99	High
	Very low nausea/vomiting at effective dose	Incidence of nausea/vomiting in single dose Phase I & II subjects (food and dose dependent) similar to opioids	Medium Low	9/99	High
	Other safety OK	Simplify profile	Medium	9/99,	High

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				2Q01	
	No significant or sustained differential efficacy in nicotine users vs. non-nicotine users	No difference seen in efficacy to date	Low?? HIGH?	9/99, 2Q01	High ?Med
	No significant or sustained differential negative side effect profile in nicotine users vs. non-nicotine users	Lower incidence of AEs in nicotine users in Phase II trial	High	9/99, 2Q01	Medium
	No re-initiation of cravings in ex-nicotine users	Possible due to nicotinic mechanism	Medium	2Q01	High
Onset of action in less than 30 minutes	Onset of action at 1.5 to 2 hours	Onset of action estimated at 90 minutes in Phase II trial	Low??	9/99	Medium
BID/TID dosing	BID/QD dosing	Competitive dynamics highlight importance of dosing convenience	High ?med	9/99	Medium
No major drug interactions, especially with drugs used for common chronic conditions	No change	N/A	High	4Q00	Medium

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C.2.2 Target Product Label

Label Requirement	Desired Label claim/ Minimally Acceptable Criteria for a Commercially Viable Product/Competitive Advantage	Regulatory Requirements	Studies/Activities/Other strategy to Achieve
DESCRIPTION			
Formulation			
Dose form			
Dose strength(s)			
Route of Administration			
CLINICAL			
PHARMACOLOGY			
Pharmacodynamics			
Pharmacokinetics			
Absorption/Bioavailability			
Distribution			
Protein binding			
Distribution			
Metabolism			
Elimination			
Special Populations			
Effect of age			
Effect of gender			
Effect of race			
Use in pregnant women			
Use in Nursing Mothers			
Effect of concomitant disease			
Plasma Levels and clinical effect			
• Effect of food on absorption			
Clinical Trial Data (by indication)			
Phase 3 studies			

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INDICATIONS AND USAGE			
Clinical Trial Data (only for one indication, the rest in C.P.)			
CONTRAINDICATIONS			
CONTRAINDICATIONS			
WARNINGS			
Black box warnings			
General Warnings (e.g., thrombocytopenia)			
Usage in Pregnancy			
PRECAUTIONS			
General			
Information for Patients			
Lab Tests			
Drug Interactions			
Drug/Lab Test Interactions			
Carcinogenesis			
Mutagenesis			
Impairment of Fertility			
Pregnancy			
Nursing Mothers			
Pediatric			
Geriatric			
ADVERSE REACTIONS			
Controlled Phase III study data (by indication)			
Other patient populations			
OVERDOSAGE			
OVERDOSAGE			
DOSAGE AND ADMINISTRATION			
By indication (dose/levels/length of treatment)			
Monitoring of Patients			
General dosing advice			
HOW SUPPLIED			
HOW SUPPLIED			

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C.2.3 Desired Promotional Claims

Table C.2.2 below, outlines the minimally acceptable criteria for a commercially viable product for ABT-594. Items in shaded boxes are NOT FUNDED.

C.2.2. Desired key messages should follow.

Desired key message	Regulatory requirement	Measures	Timing	Study Number	Type of measure	Probability	Risks Impact	Comments/Risks
Significantly Reduces pain associated with diabetic neuropathy	At least 2 adequate, well controlled studies	11 point Likert pain intensity	Launch	Phase III studies (TBD)	Efficacy	Low	High	
Efficacy and tolerability comparable to COX-2 and/or ibuprofen in OA	At least 2 adequate, well controlled studies	WOMAC, 4-point categorical pain intensity	Launch or ASAP II launch with neuropathic pain indication	Phase III studies (TBD)	Efficacy (primary patient population)	Low	High	High risk of failure due to secondary outcome differences between study populations (primary outcome). Phase III to confirm no difference in secondary outcome.
Significantly Reduces pain associated with osteoarthritis	At least 2 adequate, well controlled studies	WOMAC, 4-point categorical pain intensity	Launch or ASAP II launch with neuropathic pain indication	Phase III studies (TBD)	Efficacy	Medium	High	
Efficacy and tolerability comparable to COX-2 and/or ibuprofen in OA	At least 2 adequate, well controlled studies	WOMAC, 4-point categorical pain intensity	Launch or ASAP II launch with neuropathic pain indication	Phase III studies (TBD)	Efficacy (primary patient population)	Low	High	High risk of failure due to secondary outcome differences.
No clinically significant tolerance, dependence or withdrawal	Phase III trials; specialized addiction studies	AE reports, specific addiction measures	Launch	All studies	Safety	Medium	High	
Well tolerated in comparison to opioids, with no constipation or respiratory depression liability	Phase III trials	AE reports	Launch	All studies	Safety	Medium	High	

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Desired key message	Regulatory (FDA/EMA)	Measure	Timing	Study Number	Type of measure	Probability	Share Subject	Comments/Risks
Competitive rate of nausea and vomiting given level of efficacy. Well tolerated in comparison to commonly used pain medications	Phase III trials	AE reports and efficacy measures	Launch	All studies	Safety	Medium	High	
Easy to use with BID/QD dosing and minimal titration	Phase I/III trials, market research	Study protocols, patient surveys, MD market research	Launch	All studies	Convenience and compliance	High	High	
Cost effective	Phase III and IV	Pharmacoecomic data	Launch or shortly thereafter	TBD	Cost	Medium	Medium	Important for MC formulary acceptance
Higher patient satisfaction than other comparable medications	Phase III and IV	Survey, QoL measures (HEDIS if available)	Launch or shortly thereafter	TBD	Satisfaction	Medium	Medium	
No clinically relevant drug interactions	Preclinical? Phase III trials	Clinical and pre-clinical measures?	Launch	All studies	Safety and convenience	Medium	Medium	
Safe for long term use	Phase III extension	AE reports	Following launch?	TBD	Safety	Medium	Medium	

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C.3 Reimbursement/Pricing Strategies [Andrea/Laura to review]

C.3.1 Reimbursement/Managed Care

Pricing trends in the U.S. and European markets will remain relatively stable in the short term due to two factors. First, the effect of higher-priced branded products entering the market in each analgesic class is tempered by the loss of patent protection of other branded products, and the resulting price erosion due to generic competition. Secondly, the large size of the prescription pain market tends to absorb the impact of individual products' prices in each analgesic class. The tremendous success of the COX-2 launches, with prices xxxxxxxx in comparison to their competition, demonstrate the xxxxxx price sensitivity of this market. do average price analysis

In the long term, however, the entry of several higher-priced novel analgesics may create an upward trend in prescription analgesic prices. Reaction from government and managed care payors to rising costs could create pressure to hold prices down. A large percentage of pain medications are government paid, reflecting the age and disability of pain patients; the future political impact on this market remains uncertain.

Due to the competitiveness of the pain management market, ABT-594 must favorably complete outcomes and pharmacoeconomic studies in order to gain significant formulary acceptance and use in managed care organizations (MCOs) and institutional settings. Positioning ABT-594 against analgesic procedures (eg: epidurals), would provide argument for MC acceptance but potentially niche the product to severe pain market. It is likely that substantial rebating will be necessary if the chronic nociceptive pain market is targeted; if neuropathic pain is primary focus, more price flexibility may be present due to the smaller patient population and high level of unmet need. Marketing research and consultation with the PPD managed care department will help determine the appropriate number of studies, comparators and desired endpoints. Inclusion of these measures into Phase III trials is key for the early acceptance and success of this product.

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Table C.3.1. Reimbursement/Managed Care		
Pricing Strategies	Requirements/Status (i.e. met or unmet)	Strategy to Achieve
US <ul style="list-style-type: none"> • Third party/MCO reimbursement • Managed care • Formulary acceptance • 3rd party payers • Government reimbursement Medicare/Medicaid 	<ul style="list-style-type: none"> • Unmet • Unmet • Unmet 	<ul style="list-style-type: none"> • Quality of life and pharmacoeconomics end points in Phase III studies • Pharmacoeconomic model • First in class
Europe <ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Unmet 	
Japan <ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • Unmet 	

C.3.2 Pricing Strategy [Andrea/Laura to complete]

a. U.S.

The impact of COX 2s

b. Rest Of World

C.4 Sales Forecast(s) for ABT-594 [Andrea/Laura to update]

C.4.1 U.S. Sales Forecast

The U.S. sales forecast for the neuropathic and chronic persistent pain market is shown in Table C.4.1, below.

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Table C.4.1 U.S. Forecast (Date of Forecast: 7/00)					
	2004	2005	2006	2007	2008
Chronic Persistent Nociceptive (OA) Market Rxs (MM)	18.4	19.0	19.7	20.4	21.1
- % chg	3.5%	3.5%	3.5%	3.5%	3.5%
Neuropathic Market Rxs (MM)	10.7	11.3	11.8	12.4	13.0
- % chg	5%	5%	5%	5%	5%
Abbott Share CPN(%)	1%	3%	6%	8%	10%
Abbott Share NP(%)	4%	8%	12%	16%	20%
Abbott Rxs CPN(000)	165	544	1,183	1,632	2,111
Abbott Rxs NP(000)	427	903	1,418	1,986	2,606
Price/Rx (WAC) (2%/year increase)	\$73.40	\$74.90	\$76.40	\$77.90	\$81.10
Abbott Sales (\$MM)	\$39.4	\$98.2	\$166.7	\$236.5	\$314.5
R&D (\$MM)	18	8	3	3	3
SG&A (\$MM)					
SMM (%)					
Div. Margin (\$MM)	(\$39.6)	\$31.2	\$106.8	\$174.7	\$252.1

10 year pre-tax NPV @ 12.5% = \$1.016 B

10 year post-tax NPV @ 12.5% = \$587 MM

Key forecast assumptions:

- First in-class ChCM-Neuronal Nicotinic Receptor compound for pain to market
- Indicated for treatment of neuropathic pain; publication on use, or indication, in OA in 2006
- Effective in neuropathic pain—No addictive potential
- Titration of 3-5 days
- Efficacy equal to gabapentin, ibuprofen
- Good tolerability and safety profile; comparable to gabapentin, COX-2s
- Peak share 20% in neuropathic pain, 10% in chronic, persistent nociceptive pain
- NDA Filed 5/03, Launch 5/04
- Cost comparable to Neurontin
- Usage = 70% chronic and 30% acute
- Weighted average days per Rx = 15.6
- Stocking at 8% of first year's sales
- Physician targets: D6-10 Neuros, D3-10 Rheumatologists/Endocrinologists, D9-10 PCPs
- Sampling at 80% of details at launch, 5 units per detail, 7 days of therapy per unit
- Significant promotional and PR spend in early years
- Significant payor discounting

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- Patent expires 12/2016

Forecast Update Plan:

Forecast will be updated pending analysis of Phase IIb clinical trial results (March or April 2001) or before if the clinical trial plan changes from current assumptions. ~~in late June/early July 1999 to account for revised indications of OA and/or neuropathic pain and the associated spillover use in other pain states. Forecast will be available well in advance of ABT-594 Go/No-Go decision in 9/99.~~

C.4.2 Ex-U.S. Sales Forecast

The Ex-U.S. sales forecast is shown in Table C.4.2, below.

Table C.4.2 Ex-U.S. Forecast (Date of Forecast: 6/98)					
	2004	2005	2006	2007	2008
Market Rx's (MM)	-	-	-	-	-
- % chg					
Abbott Share (%)	1%	2.5%	3.8%	4.5%	5.0%
Abbott Rx's (MM)	-	-	-	-	-
Price/Rx (\$)	-	-	-	-	-
Abbott Sales (\$MM)	60	150	250	300	320
R&D (\$MM)	3.4	3.2	2.8	2.4	2.0
SG&A (\$MM)	27	53	50	48	45
SMM (%)	95%	95%	95%	95%	95%
Div. Margin (\$MM)	26	85	182	235	251

10 year pre-tax NPV @ 12.5% = \$428

10 year post-tax NPV @ 12.5% = \$253

Key assumptions:

- First in class ChCM
- Indicated for treatment of moderate to moderately-severe pain
- Effective in neuropathic pain
- Good tolerability and safety profile
- ~~No nicotine effects~~ (impossible as then wouldn't work!) No addictive potential
- Launched in all AI regions, including Japan, simultaneously (2003)

Forecast Update Plan:

Forecast will be updated 9/99 (in time for the Go/No-Go decision) to reflect results of marketing research to be conducted 3Q 1999 regarding expected uptake of 594 in OA and neuropathic pain markets, as well as potential spill-over prescribing for other pain states.

C.4.3 Global Sales Forecast

The global sales forecast is shown in Table C.4.3, below.

Table C.4.3 Global Forecast					
	2003	2004	2005	2006	2007
U.S. Sales (\$MM)					
Ex-U.S. Sales (\$MM)					
Total Sales (\$MM)					
Total Division Margin (\$MM)					

10 year pre-tax NPV @ 12.5% = \$B

10 year post-tax NPV @ 12.5% = \$ MM

C.5 Facilitating Launch and Market Penetration [Andrea/Laura to review]

Physicians, including neurologists, pain specialists, rheumatologists, and PCPs internists/GPs, use analgesics in various pain states based upon efficacy in representative pain states such as diabetic neuropathy pain or osteoarthritis pain. Quantitative market research performed in 1999 demonstrated dramatic off label use in pain states similar to diabetic neuropathy pain and osteoarthritis where physicians are presented with an indication in these states alone.

C.5.1 Activities to Facilitate Launch	
ACTIVITY	PURPOSE
Phase III studies in diabetic neuropathy pain	Demonstrate efficacy in a reference pain state that creates a foundation for efficacy in all neuropathic pain states
Phase III studies in osteoarthritis	Demonstrate efficacy in a reference pain state that creates a foundation to efficacy in all chronic nociceptive pain
Pain Specialist Advisory meetings	Permits up to date knowledge of market science and pain treatment trends while building base of supportive, receptive opinion leaders with in-depth knowledge of ABT-594 (and entire neuronal nicotinic receptor program)
Medical education	Primes market with information regarding advances in pain management and introduces neuronal nicotinic receptor class to speed market familiarity and uptake
Information dissemination to publishers	Allows for discussion of class to be included in texts, professional newsletters, pharmacy alerts, etc. to build awareness and understanding of technology (NNR) pre-launch
Managed Care Director Advisories/Roundtables	Allows Abbot to gain understanding of reimbursement environment for pain products, key data that MCOs will need for formulary decisions to potentially include in Phase III clinical trial design
Publication of NNR and ABT 594 specific data at key meetings and in professional journals	Prime market with information regarding advances in pain management and introduce neuronal nicotinic receptor class to speed market familiarity and uptake
Public Relations Activities (media releases, etc.)	Increase general public's comfort level of nicotinic nomenclature particularly regarding the safety and lack of addictive potential for these drugs; may also generate excitement and pull-through demand
Market Research	Determine key drivers of pain prescribing, critical data points, entry niches, and compelling key messages

C.5.2 Communication Strategy [Andrea/Laura to review]

A comprehensive communication strategy for ABT-594 as a stand alone product and as the first product of the neuronal nicotinic receptor (NNR) class is in development. Due to the importance of the entire NNR program, a specialized communications strategy vendor (Ingenix) will be working with the internal ABT-594 team to craft the plan. The overall NNR program strategy will be focused on maximizing the market potential for ABT-594 and other compounds by:

- positioning these agents as novel, effective and safe

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- generating awareness and educating prescribers and consumers about the NNR class and ABT-594 specifically
- establishing Abbott as the market leader in NNR science

Key to success of this strategy will be the cohesive, coordinated, and aligned efforts of R&D, commercial and public affairs. NUDR Discovery, the Analgesia Venture, NPD, AI NPP, and Public Affairs will work together with the vendor to lay out comprehensive Scientific, Marketing, and Public Relations plans that will outline communication timing, content, audience, and venue for all ABT-594 data. The primary goals of the communication strategy will be:

- position Abbott as the leader in NNR drug development
- augment internal development efforts
- build a base of supportive opinion leaders
- allay consumer concerns regarding the association of these compounds with nicotine
- build a framework for NNR product positioning
- generate market awareness for upcoming product launches

A complete communication strategy publication will be prepared during the third quarter of 2000.

- ~~The communications strategy for ABT-594 is under development. A vendor, specializing in the development and execution of communication strategies (e.g., Applied Clinical Communications) will be hired in 3Q, 2000 to develop the strategy, including proposed publications and venues for dissemination (e.g., journals and scientific meetings).~~

H.5 Patent Issues [Andrea/Jim S. to review] getting copy of patent to consider if we need to explore expanding its scope.

A notice of allowance has been obtained from the United States Patent and Trademark Office on an application providing generic coverage for ABT-594 and a large class of structurally related analogs. The original filing date for this application dates back to October 9, 1992, and since this predates a 1996 change in patent law, we are afforded a choice of 20 years from date of filing or 17 years from date of issue, of which 17 years from issue provides the longer patent life. The anticipated expiration of patent coverage for composition of matter for ABT-594 will be June, 2016. An additional application (6013.US.01), which includes species claims to ABT-594 as well as use claims for the treatment of pain, was filed in December, 1996 and is pending. If this patent is allowed, it will provide 20 years from date of filing, which will extend the patent life of ABT-594 to December, 2016.

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The original application providing generic composition of matter coverage was filed broadly ex. U.S. (WO94/08992) and this application published on April 28, 1994. A second foreign filing (WO96/40682) published on December 19, 1996. These cases are all still pending.

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Addenda

1.1 Highlights re: ABT-594

1.2 Historical Changes to ABT-594 Target Product Profile

- At PPCC, indications considered for ABT-594 were acute vs. chronic pain, with an acute pain claim being considered to have a shorter development course (if long term toxicology studies were not required).
- The FDA (3/98) related their concern that an oral dosage form may be used for chronic therapy even if labeled for acute. Long term toxicology would be required, therefore, even for acute claims.
- Decision analysis review of the program (3/98 - 7/98) arrived at several conclusions:
 - A general pain indication associated with a longer development cycle had greater value than an acute indication associated with a shorter development cycle.
 - Carcinogenicity studies should be initiated prior to first Phase II results.
 - Follow-on compounds (in the same cholinergic channel modulator class and in different pharmacologic classes) should be developed.
- Data from the first Phase II study (single dose molar extraction) indicated that ABT-594's onset of action is 1.5 - 2 hours post dose. Because a general pain indication requires efficacy in acute pain states (with more rapid onset of action), ABT-594 was considered unlikely to achieve a general indication. The current clinical plan targets disease-specific chronic pain indications.

The global target indications for ABT-594 are for the treatment of pain associated with diabetic neuropathy and for the treatment of pain with osteoarthritis.

Landsberg Dep. Ex. 6 / PLs' CO

Laura Robinson

08/21/2000 12:07 PM

To: Andrea Landsberg/LAKE/PPD/ABBOTT@ABBOTT
cc: Michael K Blameson/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT
Subject: Re: ABT-594 Commercial Section w/ Laura Robinson Input

Thanks for the clarification Andrea...

Changing target profile for N&V to "low" probability should suffice, rather than changing the target itself.

I still think the COX-2s are too high a standard in terms of tolerability, at least based on Jim's and my original forecasting assumptions for the September 1999 Portfolio review, which set market share at 10% of PCN and 20% for NP.

I agree we cannot be too far behind current treatments in terms of tolerability, but our (J. Doran's and my) assumptions for the September 1999 forecast used tramadol as the benchmark for AEs and efficacy in persistent chronic nociceptive pain, and gabapentin as the benchmark for efficacy in neuropathic pain (tramadol has 34% nausea, 31% dizziness, 23% somnolence and 13% vomiting; neurontin has 6% nausea, 27% dizziness, 31% somnolence and <5% vomiting).

The profile presented at the September portfolio review for PCN was "better efficacy than COX-2's/NSAIDS and tramadol with comparable AE's to tramadol (or better, with titration). For neuropathic pain, target efficacy was greater than gabapentin (AE profile for neuropathic pain vs nociceptive pain was not well defined, except to say that with titration, AE's could be somewhat worse than gabapentin, assuming greater efficacy. Appropriate trade-off between N&V, dizziness, somnolence, etc. will be difficult to judge without market research)

The market share in nociceptive pain (target market is limited to "persistent chronic", which is only 9.4% of the chronic pain population (base on J. Doran's estimates), and assumes only 10% share of this PCN market) reflects the fact that we do not expect large uptake in the patient segment that will experience adequate pain relief from COX-2s. We target efficacy greater than COX-2s and, therefore, we are not held to the same AE profile.

Please let me know if your assumptions have changed vs. the J. Doran's original (September 1999) forecast - your total sales numbers do look somewhat higher (\$367MM in 2008 vs current \$446MM), although your share assumptions are the same. Otherwise, I think the profile assumptions outlined under the forecast section should reflect the assumptions presented in the last Portfolio Review (efficacy superior to COX-2's/NSAIDS and tramadol in chronic nociceptive and superior to gabapentin in neuropathic pain; AE profile comparable to tramadol (or better with titration)

We can continue to discuss before final draft is due

Best Regards,

Laura

Laura

Andrea Landsberg

Andrea Landsberg

08/21/2000 10:56 AM

Landsberg
REP. EX. NO. 6
FOR ID., AS OF 2-16-07 BC

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To: Michael K Biarnesen/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Laura Robinson/LAKE/ABBOTT@ABBOTT

cc:

Subject: Re: ABT-594 Commercial Section w/ Laura Robinson Input

Review of Laura's edits:

No issues, of course, with any of the ex-us data or verbiage.

Positioning options - okay to change (Laura - I was taking comparable tolerability to not be applying just to N&V)

Target profile -- we changed the 'probability' for low N&V to LOW; I assumed we were trying to keep the 'history' of these changes so left as is -- if it is typical that we change these targets to reflect higher probability outcomes, it is fine with me to change.

Target product label -- I agree we are likely not to achieve such levels, however we need to be 'targeting' keeping these as low as possible via titration/ alternate formulations/ etc. These numbers were not meant to be 'absolutes' from me, just starting points for us to keep in mind vis-a-vis the competition -- Aldona and I discussed last week.

Pricing/reimbursement -- okay to change

Forecast assumptions -- again, not taking tolerability and safety to only be applying just to V&N; was thinking of dizziness re: gabapentin; also, COX-2s do have a lot of nausea that may have persistent duration, perhaps unlike 594's which may be transient (related to increasing dose) -- I do think, at least in the US, unless we are targeting just current opioid-using, severe pain population we will have to not be that far behind these products (gabapentin and cox2s) in tolerability to get any use (especially in 2004). I am using this here to be sure we stay very aware of just how important this issue of tolerability is to gain any market share. I also thought that we were assuming the current trial with titration was supposed to greatly reduce the N&V issue (please let me know if this is a misunderstanding on my part -- I know we have some definite signs that that is likely not the case (re: early discontinuations), but should we be adjusting assumptions before we really have all the data analyzed?

Table C4.2 -- noticed that the title says US, not Ex-US forecast

That's all I had comments on -- please let me know what the consensus views are. Mike, will we have one final chance to review the entire document again so that Laura and I can be sure we are comfortable with it in all its nuances?

Thanks,
Andrea

Michael K Biarnesen



Michael K Biarnesen

06/21/2000 09:04 AM

To: Catherine K Kacos/LAKE/PPRD/ABBOTT@ABBOTT
cc: Andrea Landsberg/LAKE/PPD/ABBOTT@ABBOTT, Aldona T
Matalonis/LAKE/PPRD/ABBOTT@ABBOTT, Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Laura
Robinson/LAKE/ABBOTT@ABBOTT
Subject: ABT-594 Commercial Section w/ Laura Robinson Input

Cathy,

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Attached is the commercial section with input from Laura (shown as edits in red.) I have also included some clarifications that Andrea and I agreed to. Please incorporate these changes into the controlled draft. Do not pick-up any edits to the draft label section without Aldona's input (Aldona - please review.)

Andrea / Bruce, Laura raises some questions in her input, most significantly the question in her cover note below. Please review and comment.

Mike B :



594 development plan - commercial sections, 6-21 with Laura Robinson & Mike B
----- Forwarded by Michael K Blarnesen/LAKE/PPRD/ABBOTT on 08/21/2000 09:00 AM

Laura Robinson
08/20/2000 06:27 PM

To: Michael K Blarnesen/LAKE/PPRD/ABBOTT@ABBOTT, Andrea
Landsberg/LAKE/PPD/ABBOTT@ABBOTT

cc:

Subject: Re: revised 594 development plan

I was out of the office all last week at an Abbott off-site.

Attached are my edits. The only issue I have is that we still seem to be over-promising on the profile for ABT-594 regarding tolerability. There are several places where "tolerability comparable to COX-2s" is mentioned. I think this is completely out of the realm of possibility. What about changing it to "tolerability no worse than oxycontin" or maybe our target is better than that with titration, e.g., "comparable to gabapentin after titration". I don't believe that Jim Doran's any my original assumption for chronic nociceptive profile was "tolerability like COX-2s with high efficacy". I remember talking about tramadol as the benchmark, which still has fairly significant nausea/vomiting relative to typical NSAIDs.

What is your view on this?

Regards,

Laura

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B. Marketplace: Chronic Neuropathic and Nociceptive Pain**B.1 a Chronic Neuropathic Pain Marketplace SWOT Analysis**

Table B.1a includes a summary of the strengths, weaknesses, opportunities and threats associated with the Chronic Neuropathic Pain marketplace with respect to the development of ABT-594.

Deleted: information presented in this section

Table B.1a SWOT Analysis (Strengths/Weaknesses/Opportunities/Threats)		
CATEGORY	ITEM (Impact)	STRATEGY
Strengths	Indication in neuropathic pain will likely lead to spillover use in chronic nociceptive pain (High)	Obtain indication for neuropathic pain (as broadly as possible)
	Few products have indication for neuropathic pain, which should limit the sales and marketing efforts required to penetrate the market (High)	Conduct or fund trials in neuropathic and chronic nociceptive pain beyond diabetic neuropathy
	Increasing incidence of diabetes and subsequent diabetic neuropathy market (Mod)	Capitalize on indication labeling through appropriate sales and marketing campaign
	Bulk of competition is generic (Mod)	
Weaknesses	Current leading treatment (gabapentin) perceived as effective, safe and well tolerated (High)	Conduct trials to compare efficacy and tolerability to market leaders
	Diabetic and other neuropathies are often underdiagnosed and mis/under-treated (Mod)	Monitor competitive landscape and adjust clinical development and marketing strategies appropriately
	Painful aspect of neuropathy is not always present or persistent (Mod)	Take advantage of cross-divisional expertise and presence in markets new to PPD (e.g.: Modisense in diabetes)
	Limited regulatory history for indication (Mod)	Support screening and aggressive treatment of diabetic and other neuropathies
Opportunities	Advances in the treatment of glycemic control could decrease the rate at which diabetic neuropathy occurs (Low in near term)	Work closely with regulatory and plan for 'End of Phase II' FDA meeting
	Large unmet need for effective treatments (High)	Demonstrate equal or better efficacy to currently available agents
	Increasing focus on aggressive treatment of pain (Mod)	Demonstrate equal or better tolerability to currently available agents
	Novel mechanism may generate increased excitement (Low)	
Threats	Gabapentin follow-on compound, pregabalin, may be even more effective than gabapentin and may pursue indication for neuropathic pain (High)	Maximize efficacy, safety and convenience of compound and formulation
	Pricing pressure from managed care, government due to shift from low cost generics (Mod)	Conduct pharmacoeconomic studies and garner support of patient advocacy groups
	Nicotine association could decrease public acceptance and raise fears regarding addictive potential (Mod)	Develop and execute public relations plan to allay fears regarding nicotine
	Treatment aimed at the underlying neuropathic process (e.g. bimocloamol for diabetic neuropathy)	Conduct studies to demonstrate non-addictive nature of compound

Version 1, revised 7/31/2006;...in development plus 2006 revised July

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could limit market for neuropathic pain agent (Low)

B.1 b Chronic Nociceptive Pain Marketplace SWOT Analysis

Table B.1b includes a summary of the strengths, weaknesses, opportunities and threats associated with the Chronic Nociceptive Pain marketplace with respect to the development of ABT-594.

Deleted: Information presented in this section

Table B.1b SWOT Analysis (Strengths/Weaknesses/Opportunities/Threats)		
CATEGORY	ITEM (Impact)	STRATEGY
Strengths	Large, growing market consisting of primarily OA, RA and back pain (High) Increasing incidence of chronic pain conditions with aging population (Mod) Over 50% of chronic pain patients take a medication every day (Low)	Conduct trials in OA or other chronic nociceptive pain areas for indication or publication
Weaknesses	Titration may limit use relative to competitors (Mod)	Optimize titration schedule for least impact on prescribing and work on formulation to minimize or eliminate need for titration <i>Consider addition of titration package for sales / samples</i>
Opportunities	Significant unmet need for alternative to opioids that have equal efficacy with less side effects and no scheduling (High) "Ceiling effect" of NSAIDs and COX 2 competitors (Mod) Novel mechanism may generate significant degree of interest and trial (Mod)	Conduct opioid sparing or opioid replacement trials Conduct studies to demonstrate non-addictive nature of compound Position 594 as 'bridging' compound after ceiling effect reached and before use of scheduled narcotics
Threats	COX -2s may be firmly entrenched as market leaders for all chronic pain conditions (Mod) Combination products combining opioids with non-opioid analgesics or potentiators may meet market demand for improved side effect profile and offer steep competition (Mod)	Demonstrate key benefits over current and potential competitors in terms of efficacy or safety Carefully position along pain severity spectrum to preserve a target patient population

Deleted: to

B.2 Epidemiology/Disease Class

Pain is the most common symptom of disease and the most frequent complaint with which patients present to physicians. Chronic pain, including both neuropathic and nociceptive pain, is considered to be the single most common cause of suffering and disability in the industrialized

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world with an estimated 25-30% of the population experiencing some form of chronic pain. Chronic neuropathic pain is a frequent sequela of diabetes, cancer, AIDS and other viral infections, as well as 'entrapment' disorders such as carpal tunnel syndrome.

Diabetes and its major cause, obesity, are increasing at an alarming rate in the United States; the number of type II diabetics is estimated at 15 million in 2000. Despite advances in treatment, the development of diabetic complications such as neuropathy remains significant. The diagnosed prevalence of diabetic neuropathy is estimated to be about 2 to 3 million patients, with at least 10 to 20% of those patients experiencing painful symptoms.

It is estimated that almost a million people in the U.S. and 35 million people world-wide are infected with the AIDS virus. AIDS related neuropathic pain is estimated to affect approximately 40% of HIV-infected individuals. The primary form is a distal, symmetric, predominantly sensory neuropathy. A 1996 study found that only 15% of patients with AIDS related pain receive adequate treatment for their pain, with 25% receiving no analgesics and 40% being prescribed only NSAIDs indicating a significant unmet need for analgesia in this population. Post-herpetic neuralgia is another virally induced neuropathic pain syndrome. Annually, acute Herpes zoster infection (shingles) occurs in almost a quarter of a million people over the age of 60 in the US alone. Pain lasting more than one year has been reported in 22% of patients over the age of 55 and in 48% of those over 70 years of age. The incidence of acute shingles and subsequent post-herpetic neuralgia is likely to increase with the aging population.

In cancer, nerves can be damaged by mechanical distortion from a tumor mass, chemotherapy, or radiation therapy and therefore neuropathic pain is common. A 1999 report showed that 36% of cancer patients suffer from neuropathic pain and it is estimated that in half of cancer patients whose pain is rated as moderate or greater that primarily a neuropathic, rather than nociceptive, pain process is the cause. An estimate of the prevalence rate for cancer-related neuropathic pain in the US is 200,000.

Other neuropathic pain syndromes include entrapment neuralgias such as carpal tunnel syndrome (estimated 1% of the population) and some chronic low back pain patients (up to 10% of all chronic back pain is thought to be neuropathic in origin). Additional etiologies of neuropathic pain include amputations, multiple sclerosis, reflex sympathetic dystrophy, stroke, and spinal cord injury.

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Chronic nociceptive pain categories include osteoarthritis, chronic back and neck pain, rheumatoid arthritis, and cancer pain and these diagnoses are expected to become more prevalent as the population ages. Current overall prevalence for these disorders is staggering, over 200 million worldwide, and, although the diagnosed and treated populations are lower, improved treatment options and awareness have the potential to drive significant growth. Osteoarthritis (OA) is one of the most common nociceptive pain conditions treated by primary care physicians and three-fourths of OA sufferers surveyed indicate that the disease interferes with their daily activities. Chronic back and neck pain are also highly prevalent and represent an estimated 40% of a PCP's chronic pain patient population.

A summary of the prevalence of relevant chronic pain diagnoses is shown in Table B.2c.

Table B.2c Prevalence of Key Target Pain Diagnoses		
Diagnoses	Est. 2000 Prevalence (MM)	
	U.S.	Ex-U.S. ³
Neuropathic Pain in Diabetic Neuropathy ¹	0.6	0.9
Postherpetic and Trigeminal Neuralgia ¹	0.5	0.7
Osteoarthritis ²	9.4	24.3
Chronic Low Back Pain ²	8.5	21.6
Rheumatoid Arthritis ²	1.9	2.9
Cancer Pain ²	1.0	1.2
Total for Key Pain Diagnoses	21.9	51.6
1. Decision Resources, 1999. 2. Decision Resources, 1999 (Data presented reflects <i>diagnosed</i> prevalence) 3. Germany, France, Italy, Spain, UK, and Japan.		

B.3 Market Overview

The economic burden of pain in the United States is estimated to be \$100 billion a year in direct and indirect costs. Approximately 95 million Americans per year receive drug therapy for pain.

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which represents only about 50% of those who suffer from pain. Physician or patient concern about drug safety and side effect profiles, fear of addiction, the use of OTC therapies, or non-pharmacological treatments account for the 30-50% of patients who seek treatment for pain but are not prescribed an analgesic. Efforts to change this mindset, however, are likely to result in a greater percentage of sufferers receiving pharmacologic therapy. Pain specialists, advocacy groups and patients have campaigned vigorously for more aggressive treatment of pain over the last decade. One trend toward acceptance of this more aggressive treatment approach is the 11% and 14% growth (1999 over 1998) for codeine/codeine combination agents and morphine prescriptions respectively. ~~US sales of narcotic analgesics have also increased significantly, with an annual growth rate of 14% from 1997 to 1999. In the US, the great success of the recently launched COX-2 analgesics, achieved by growing the market with minimal erosion of the NSAID class, speaks to the increasing consciousness regarding pain management and the high unmet need for drugs that are safer, yet maintain equivalent efficacy, than those currently available. It is expected that, as improved treatments become available and awareness of the long term benefits of adequate pain management becomes widespread, the pain market will grow considerably. US sales of the COX-2's have been much less spectacular (\$1.37MM in 1999), likely due to the significant price premium over traditional NSAIDs in an era when government health systems are experiencing downward pricing pressure. New pain treatments will need to demonstrate significant improvements over currently available agents to ensure regulatory approval (particularly in Europe) and widespread usage by physicians, who are increasingly involved in cost containment measures.~~

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Chronic pain sufferers may account for as much as 20% of the adult population implying over 130 million adults in the seven major pharmaceutical markets suffer from chronic pain. It is estimated that only one-half of chronic pain patients obtain adequate pain relief. The chronic pain market can be segmented into two major groupings, neuropathic and nociceptive. Chronic neuropathic pain includes the pain associated with diabetic polyneuropathy, post-herpetic neuralgia, sciatica, entrapment neuropathies (such as carpal tunnel syndrome), phantom-limb syndrome, and others. Chronic nociceptive pain includes pain associated with osteoarthritis, rheumatoid arthritis, lumbar spine disease, cancer, and other causes. Neuropathic and nociceptive pain differ in symptoms, pathophysiology and treatments.

Neuropathic pain is a significant, yet largely untapped market. Estimates vary widely for the number of worldwide sufferers, from as low as 20 million to as high as 50 million or more. Estimates of the number of cases is limited by inadequate epidemiological studies. One report puts the total US prevalence of neuropathic pain at 4 million. Neuropathic pain is often treated

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with tricyclic antidepressants (TCAs), anticonvulsants (e.g. gabapentin) and alpha adrenergic agonists; collectively, these drug classes are sometimes referred to as "adjuvant pain medications". An estimated 50% of drug uses for neuropathic pain conditions are for anti-epileptic agents, with the TCAs accounting for about 25% of uses. PCPs prescribe OTC analgesics or prescription NSAIDs for neuropathic pain more than other specialties, even though there is little evidence for their usefulness in for this condition.

US sales in 1999 for the key ~~non-steroidal~~ neuropathic pain treatments, Neurontin, carbamazepine, and tricyclic antidepressants (TCAs), are estimated to be \$350 million. Neurontin sales account for the bulk of this, with an estimated 40% of this antiepileptic drug's sales being for neuropathic pain; Neurontin's 2000 sales are expected to reach \$1 billion with perhaps 50% of its uses being for neuropathic pain. This dollar market value likely underestimates this market's potential due to a number of factors. Only the anticonvulsant Tegretol (carbamazepine), which is off-patent, has a specific indication for neuropathic pain in the US (although Neurontin (gabapentin) recently received an indication in the UK for the treatment of neuropathic pain). Therefore there has been no funding from the pharmaceutical industry to improve diagnosis and treatment of neuropathic pain and drive market growth. Of even greater impact on total market sales, most of the agents used to treat this population, with this exception of Neurontin, are low cost, generic products.

Ex-US sales of carbamazepine and Neurontin for treatment of neuropathic pain are estimated to be approximately \$140MM in 1999. Carbamazepine is still the treatment of choice ex-US, with sales of approximately \$60MM in neuropathic pain. Neurontin has achieved only \$53MM in sales for this pain segment, with a price approximately 3-4 times that of carbamazepine, suggesting a patient share of only 10-20%.

Significant unmet need remains in the treatment of neuropathic pain since few medications provide complete pain relief and most adjuvant medications have significant side effects. As the prevalence of the underlying disorders (diabetes, herpes zoster, etc) increases with the aging population and more effective and tolerable medications become available, the neuropathic pain market has the potential to experience significant growth. The following tables show the factored U.S. and ex-U.S. prescription and sales volume for key neuropathic pain therapies 1999.

Table B.3a. 1999 Key Neuropathic Pain Products, Estimated TRxs

Class	1999 U.S. TRx	U.S. TRx CAGR	1999 ex-U.S. TRx	ex-U.S. TRx
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	(MM)	'97-'99	(MM)	CAGR '97-'99
Neurontin	3.3	26.3%	N/A	N/A
Carbamazapine	1.0	12.6%	N/A	N/A
TCA's	8.2	1.1%	N/A	N/A
TOTAL	12.5	5.6%	N/A	N/A

Source: IMS, factored for neuropathic uses.

N/A = not available

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Table B.3b. 1999 Key Neuropathic Pain Products, Estimated \$ Sales

Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR '97-'99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR '97-'99
Neurontin ..	\$308	28.7%	\$53	21.6%
Carbamazapine	\$17	13.1%	\$82	2.5%
TCAs	\$26	-3.3%	NA	NA
TOTAL	\$351	21.7%	\$135	14.1%

Source: IMS, factored for neuropathic uses

Ex-U.S. data includes retail pharmacy data from all audited markets.

Deleted: and hospital data from major
European markets and Canada only.

Nociceptive pain is categorized by duration (acute or chronic) and by severity (mild, moderate, and severe). The mild and, to a lesser extent, moderate segments have multiple product entries and are generally well satisfied by OTC products such as aspirin, acetaminophen, ibuprofen. The prescription market for nociceptive pain is made up of four key classes of analgesics: NSAIDs, COX-2s, Opioids (and combination products), and Other Non-Opioids (including aspirin, acetaminophen, and synthetic non-opioids).

Prescription NSAIDs are generally written for chronic pain of moderate severity. NSAIDs/COX-2s exhibit analgesic and mild anti-inflammatory properties, and are drugs-of-choice in such pain conditions as osteoarthritis, rheumatoid arthritis and lower back pain. NSAIDs/COX-2s have fewer central nervous system side effects than opioids. NSAIDs, however, can cause potentially serious renal and gastrointestinal side effects, including gastric ulceration and bleeding. COX-2s may appear to have a lower rate of these adverse events, due to increased selectivity of action. However, current COX-2s do not eliminate the risk of GI complications completely. Another drawback of NSAIDs/COX-2s is the presence of a 'ceiling effect' in which even additional amounts of drug fail to increase analgesic activity. This factor often leads to the use of stronger analgesics such as opioids.

The moderate and severe segments of the market have many opioid product offerings that are mostly generic, undifferentiated and inexpensive. While opioids and combination opioids accounted for the majority (53%) of analgesic prescriptions in 1999, they account for less than one-third of the prescription analgesic sales. Some branded opioids, however, have recently been very successful (OxyContin is projected to have 2000 revenues of \$1 billion).

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Opioids are scheduled, a regulatory status that creates administrative burdens and barriers to prescribing and these barriers are particularly high in European markets. In general, opioid use ex-US is largely restricted to cancer pain and there exists a large unmet need for effective treatment of severe pain. There are significant country to country differences, however.

Physicians in Scandinavia, the UK, and France are more likely to prescribe opioids compared to other ex-U.S. countries and ~~usage has~~ increased considerably over the past 5 years. In Italy, Spain and Germany, opioid use is extremely restricted, requiring patient identity cards and special prescription forms that must be obtained, in person, by the physician; morphine is often considered a last resort.

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In the U.S., opioid analgesics are considered the drugs-of-choice for acute nociceptive pain, especially of moderately-severe to severe intensity. However, as elsewhere, US physicians often avoid prescribing opioids for chronic pain conditions due to fear of tolerance and addiction and due to the scheduled status of this analgesic class. As mentioned previously, the efforts of advocacy groups and pain specialists are being directed at encouraging appropriate use of strong pain medications and opioids are the most commonly prescribed medication for cancer pain.

"Other Non-Opioids" include (1) non-opioid/non-NSAID agents like aspirin, acetaminophen or Ultram (tramadol), and (2) NSAIDs that are positioned and marketed primarily as analgesics, such as ketorolac or bromfenac sodium. These non-opioids are generally used in place of opioids to treat moderate pain, or in some cases, moderately-severe pain.

Most analgesics are indicated for the treatment of one or more specific nociceptive pain states (e.g. osteoarthritis). Depending on its characteristics, however, a significant number of a product's prescriptions may come from non-indicated pain states (i.e., spillover prescriptions). A product indicated for osteoarthritis, for example, is likely to be prescribed for chronic lower back pain, rheumatoid arthritis, and other pain states with similar clinical characteristics or etiologies. Efficacy in osteoarthritis has become a benchmark for analgesic efficacy in most chronic nociceptive pain states of mild to moderately severe intensity.

The following tables show U.S. and ex-U.S. prescription and sales volume for key nociceptive pain classes for 1999. Please note that up to 50% of these prescriptions may be for acute uses; also, not all chronic pain patients take medication every day and therefore also fall out of the potential population for ABT-594 treatment (due to its likely titration requirements).

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Table B.3c. 1999 Key Prescription Nociceptive Pain Products, TRxs

Class	1999 U.S. TRx (MM)	U.S. TRx CAGR '97-'99	1999 Ex-U.S. TRx (MM)	Ex-U.S. TRx CAGR '97-'99
NSAIDs	70.7	-1.4%	N/A	N/A
COX-2s	22.4	N/A	N/A	N/A
Opioids ¹	153.8	2.5%	N/A	N/A
Other Non-Opioids ²	45.4	-0.9%	N/A	N/A
TOTAL	292.3	0.8%	N/A	N/A

Source: IMS

N/A = not available or not applicable

¹Includes IMS groups: Morphine, codeine and combos, propoxyphene, synthetic narcotics (non-injectables only)²Includes IMS groups: Synthetic non-narcotics, aspirin, acetaminophen (non-injectables only)

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Table B.3d. 1999 Key Prescription Nociceptive Pain Products, \$ Sales

Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR '97-'99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR '97-'99
NSAIDs	\$1,565	-3.2%	\$3,400	-0.5%
COX-2s	\$1,558	N/A	\$124	N/A
Opioids ¹	\$2,127	8.2%	\$767	14.3%
Other Non-Opioids ²	\$1,431	-4.6%	\$1,637	0.6%
TOTAL	\$6,681	4.5%	\$5,657	1.7%

Source: IMS

¹Includes IMS groups: Morphine, codeine and combos, propoxyphene, synthetic narcotics (non-injectables only)

²Includes IMS groups: Synthetic non-narcotics, aspirin, acetaminophen (non-injectables only)

Ex-U.S. data includes retail pharmacy data from all audited markets.

Deleted: and hospital data from major European markets and Canada only.

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B.4 Current Treatment Options

TABLE B.4A CURRENT ORAL TREATMENT OPTIONS: NEUROPATHIC PAIN				
Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Antiepileptics as analgesics*	Gabapentinoids (gabapentin)	Unknown	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Effective, well tolerated, not metabolized, no drug interactions <u>Side effects:</u> Dizziness at high doses <u>Other drawbacks:</u> No neuropathic claim in US; cost; modest analgesic effect, titration
	Iminostilbenes (carbamazepine)	Slow voltage-gated Na ⁺ channel activation recovery	Trigeminal neuralgia	<u>Strengths:</u> Very effective, inexpensive <u>Side effects:</u> Ataxia, dysmetria, unsteadiness, hepatotoxicity, aplastic anemia, hypersensitivity reactions <u>Other drawbacks:</u> Drug interactions
Antidepressants as analgesics	Tricyclic antidepressants (amitriptyline, nortriptyline)	Probably inhibit biogenic amine reuptake	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Modest analgesic effect, inexpensive <u>Side effects:</u> Anti-cholinergic (dry mouth, sedation), cardiac arrhythmia, weight gain <u>Other drawbacks:</u> Cardiac effects, titration
	Mixed serotonin and norepinephrine reuptake inhibitors (venlafaxine)	Mixed serotonin and norepinephrine reuptake inhibitors (venlafaxine)	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Modest analgesic effect, inexpensive? <u>Side effects:</u> Anti-cholinergic (dry mouth, sedation), cardiac arrhythmia <u>Other drawbacks:</u> Cardiac effects, titration
Miscellaneous	Opioid and norepinephrine reuptake inhibitor (tramadol)	Opioid and norepinephrine reuptake inhibitor	Distal symmetric neuropathic pain (diabetes, HIV, idiopathic, etc.) Post herpetic neuralgia (PHN)	<u>Strengths:</u> Moderate pain relief without the opiate stigma, non-scheduled <u>Side effects:</u> Nausea, vomiting, sedation <u>Other drawbacks:</u> May reinstate physical dependence in previously opiate-dependent patients. May eventually receive scheduled status

* Many newer antiepileptic agents (e.g., Tiagabine, lamotrigine) have recently or will soon undergo clinical trials in neuropathic pain.

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TABLE B.4b CURRENT TREATMENT OPTIONS: NOCICEPTIVE PAIN

Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Opioid	Opioids (e.g., morphine, codeine)	Opioid receptor activation	Surgery, injuries, musculoskeletal disorders, cancer Moderate to severe pain Opioids are the drugs of choice for severe acute pain and cancer pain	<u>Strengths:</u> Potent analgesic effect, inexpensive <u>Side effects:</u> Constipation, Nausea and Vomiting, Sedation, Cognitive Impairment, Respiratory Depression, Pruritus <u>Other drawbacks:</u> Development of tolerance, addiction potential, scheduled drugs, do not reduce inflammation
	Opioid Combination with another analgesic (e.g., aspirin or acetaminophen)	Opioid receptor activation Combination preparation offsets opioid side effects by adding second analgesic with a different mechanism of action	Surgery, injuries, musculoskeletal disorders Moderate to severe pain	<u>Strengths:</u> Potent analgesic effect, and depending on combination agent, may also decrease inflammation and body temperature; reduced opioid side effects <u>Side effects:</u> All effects associated with each of the drugs administered, although reduced in frequency and severity <u>Other drawbacks:</u> All drawbacks associated with each of the drugs administered
Non-Opioid	NSAIDS	Inhibit the synthesis of prostaglandins, which are responsible for inflammation, increased body temperature, and sensitization of pain receptors	Osteoarthritis, rheumatoid arthritis, lower back pain, and other chronic pain conditions In addition to some mild to moderate acute pain conditions	<u>Strengths:</u> Fewer CNS side effects than opioids, and no addiction potential, inexpensive <u>Side effects:</u> Gastric ulceration and bleeding <u>Other drawbacks:</u> Ceiling effect (complete pain relief cannot be achieved even after dose escalation)

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TABLE B.4b CURRENT TREATMENT OPTIONS: NOCICEPTIVE PAIN (CONT.)				
Category	Drug Class	Mechanism of Action	Pain Treated	Issues
Non-Opioid (COX-1)	COX-2 Inhibitors (e.g., celecoxib)	Inhibit the synthesis of prostaglandins, which are responsible for inflammation, increased body temperature, and sensitization of pain receptors Preferential COX-2 vs. COX-1 inhibition may reduce risk of GI interaction	Osteoarthritis, rheumatoid arthritis, lower back pain, and other chronic pain conditions in addition to some mild to moderate acute pain conditions	Strengths: Claim fewer GI side effects than NSAIDs with similar analgesic effect Side effects: Peripheral edema Other drawbacks: cost
	Acetaminophen	Mechanism of action is poorly understood, but appears to involve effects in the CNS (has analgesic and antipyretic effects)	Sprains, strains, injuries, musculoskeletal pain, osteoarthritis Management of mild to moderate pain	Strengths: Has no effects on platelet function, has no GI toxicity; has fewer CNS side effects than do opioids, inexpensive Side effects: May be hepatotoxic in heavy drinkers and patients with liver disease Other drawbacks: Lacks anti-inflammatory activity. Ceiling effect (complete pain relief cannot be achieved even after dose escalation)
Miscellaneous	Opioid and norepinephrine reuptake inhibitor (tramadol)	Dual mechanism of action via opioid and non-opioid mechanisms (norepinephrine reuptake inhibitor)	Used in the treatment of moderate to severe pain	Strengths: Moderate pain relief without the opioid stigma, non-scheduled Side effects: Nausea, vomiting, sedation Other drawbacks: May reinforce physical dependence in previously opioid-dependent patients. May eventually receive scheduled status

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B.5 Competitive Analysis – Emerging Competition [Andrea/Laura to review]

Almost 100 compounds are currently in development for prescription pain management, though some of these compounds are also being developed for other non-analgesic indications. The majority of the analgesic compounds in the pipeline represent incremental improvements to the opioids or NSAIDs, or consist of new formulations or delivery mechanisms for the standard analgesics. Fewer than 30% of the compounds in development have novel mechanisms of action. Drugs with novel mechanisms are expected to provide the bulk of the promoted competition for ABT-594.

Among the novel agents in development, the greatest threat to ABT-594 is likely to be posed by other nicotinic compounds in development for pain. ABT-594, now in Phase IIb trials, is suspected to be the most advanced nicotinic compound in the analgesia pipeline. The first nicotinic compounds from competitors to be launched in the class may be for Alzheimer's Disease or Parkinson's Disease. These compounds do not represent a threat to ABT-594, unless significant safety concerns or evidence of tolerance, dependence or abuse are an issue and become associated with the class as a whole.

The pipeline for the treatment of neuropathic pain does not have a blockbuster compound on the order of the COX-2 inhibitors. However, pregabalin, the follow-up to Parke-Davis' Neurontin (gabapentin), is expected to perform well; analyst reports predict its sales for neuropathic pain may be almost \$100 million by 2003, its second year post expected launch. Initial data from pregabalin suggests a compound that overcomes the absorption and uptake limitations associated with gabapentin leading to a more convenient dosing schedule and resolved pharmacokinetic 'ceiling effect'. However, increased doses and corresponding increased plasma levels appear to be associated with greater efficacy and more frequent adverse events. The marketing and sales power of Pfizer is likely to drive the product to success, despite such concerns.

For the treatment of osteoarthritis (OA), the COX-2 inhibitors represent the most significant competition, with sales of a staggering \$13 billion by 2004 being predicted. Use beyond pain into colorectal cancer and neurodegenerative disorders is also being explored for COX-2s. Searle and Merck both have follow-up compounds well along in development which purport to have greater selectivity for COX-2 vs. COX-1 and therefore offer the potential for increased potency and decreased side effects. Other second generation COX-2s are in the pipeline, although J&J recently announced the decision to stop development of Japan Tobacco's compound JTE 522. Unresolved side effect issues surrounding COX-2 inhibitors remain, however, including the risks

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of thrombosis, hypertension, reproductive dysfunction and teratogenicity that may show up as the exposure to these agents becomes more widespread.

Table B.5a. Analgesia Pipeline – Key Novel Agents

Product	Company	Mechanism	Phase	Comment
pregabalin	Parke-Davis	Ca channel blocker	III	Neuropathic pain, chronic pain Follow-up to Neurontin
saredutant	Sanofi	NK-2 receptor antagonist	II	General pain MOA losing favor; active program?
ZD4952	Zeneca	prostaglandin receptor antagonist	II	Moderate to severe pain
GV196771	Glaxo	glycine antagonist	II	Chronic pain, showing promise
tepoxalin	J&J	COX/5-LO inhibitor	II	OA, described as 'steroid replacing anti-inflammatory drug'
darbufelone	Parke-Davis	COX/5-LO inhibitor	II	General pain
HCT-3012	NicOx	Nitric oxide NSAID	I	Pain and inflammation
cizolirtine	Esteve	Substance P	II	Analgesia, antipyretic

Sources: ADIS, IMS, Decision Resources, company reports

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Table B.5b. Development Pipeline – Nicotinic Mechanisms

Product	Company	Phase	Comment
GTS-21	Taiho	II	Target is Alzheimer's Disease May have preclinical pain program; looking for partner
CMI 980	Cytomed	Preclinical	Target is pain Epibatidine analog
SIB-T1887	Sibia	Preclinical	Target is pain
FID 072021	Fidia	Preclinical	Target is pain; not actively funding

Sources: ADIS, IMS, company reports

Not reflected in the above tables are the early stage programs of Merck, Sibia, etc..(Bruce to complete).....

B.6 Unmet Needs [Andrea/Laura to review]

In general, a significant unmet need exists for safer, non-abusable, non-addicting, non-tolerance producing, and non-scheduled efficacious oral and parenteral analgesic products for the treatment of moderate to severe neuropathic and chronic nociceptive pain.

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Table B.6. Unmet Market Needs and the Impact of the Pipeline

Unmet Need	Pipeline Impact
Efficacy in moderate to severe pain without tolerance, dependence or abuse	Novel nicotinic agents like ABT-594 may provide efficacy in more severe pain states without opioid-like liabilities
Efficacy in neuropathic pain	Pregabalin may provide incremental improvement in neuropathic pain efficacy over gabapentin, but may also have increased frequency of adverse events Novel nicotinic agents like ABT-594 appear to have efficacy in neuropathic pain, based on animal models
Reduction in the GI bleeding risk of NSAIDs	COX-2 inhibitors appear to reduce the incidence and severity of GI ulcers and bleeding; second generation COX-2s may increase therapeutic window further
Overcome ceiling effect of NSAIDs	Preclinical studies did not indicate a ceiling effect for novel nicotinic agents like ABT-594
Extended dosage intervals or novel delivery mechanisms for improved compliance and convenience	Once weekly dosing formulations being explored for COX-2s, etc. Patch technology improvements likely
Therapies aimed at disease modification, prevention	Agents that decrease rate of diabetic complications (e.g., aldose reductase inhibitors) or directly treat neuropathy (bimoclomol) may decrease incidence of neuropathic pain

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C. Product Positioning

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C.1 Product Positioning Options

Table C.1a includes a summary of the strengths, weaknesses, opportunities and threats associated with the information presented in this section with respect to the development of ABT-594.

Positioning alternatives/options	Strategy	Strengths	Weaknesses
Equal efficacy to Neurontin and TCAs in neuropathic pain with improved dosing, AEs, and safety	Sell against top neuropathic pain products on convenience, tolerability and safety	Efficacy to date supports BID, possibly QD dosing Low level of CNS AEs No weight gain	May have too high level of nausea and vomiting to compete with Neurontin (pregabalin?) on AEs
Better efficacy than Neurontin and TCAs with comparable dosing, AEs and safety	If AEs for ABT-594 too frequent vs. competition, sell on 'power'	Efficacy data likely to support May be better fit with AB profile	Neurontin and TCAs perceived to have high efficacy; may not be able to match Neurontin's perception as extremely safe and well tolerated
The only oral agent indicated for the treatment of neuropathic pain	Capitalize on 'government approved' status to increase prescriber confidence	Data to date supports efficacy in neuropathic pain Current timeline gives ABT-594 neuropathic pain indication by mid 2004	Pregabalin (or others?) may be to market first with neuropathic pain indication Neuropathic pain indication still uncertain from regulatory standpoint
Superior efficacy to COX-2s without ceiling effect (e.g., 1.5x). Think "unassailable tolerability" in Cox-2s. In other words, possible we will be able to have comparable tolerability to COX-2s.	Even though we have no data on efficacy, we are marketing this as a superior alternative to COX-2s.	No ceiling effect seen with ABT-594	May limit use to after COX-2 failure COX-2 agents will be firmly entrenched
Opioid-like efficacy without addictive potential and with fewer AEs than opioids for treatment of moderate to severe chronic pain	Capitalize on market reluctance to use opioids by providing safe, efficacious alternative	Provides clear, compelling reason to use and matches product profile to date	May niche ABT-594 to more severe patients and limit market

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Deleted: Attempt to enter into large market

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C.2 Target Product Profile

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C.2.1 ABT-594 Target Product Profile

Table C.2.1 below, outlines the desired target product profile for ABT-594:

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Table C.2.1. ABT-594 Target Profile

PPCC/DDC Profile (12/10/97)	Current Profile (8/00)	Rationale for Profile Change	Probability	Status	Share Impact
Indicated for the treatment of pain (general pain claim)	Indicated for the treatment of osteoarthritis pain	"General pain" claim not achievable due to slow onset of action; proof of principle established in molar extraction study Indication specific claims now favored since general pain claim not achievable, clinical studies have shown no statistically significant difference in analgesic effect between general and indication specific claims.	Medium	9/99, 1Q01	High
Effective in neuropathic pain	Indicated for the treatment of neuropathic pain	Indication specific claims now favored since general pain claim not achievable	Med	9/99, 2Q01	Medium
Effective for moderate to moderately-severe pain	N/A	No longer applicable without general pain, acute or chronic pain (not otherwise specified) claims??	N/A	N/A	N/A
Not scheduled/no abuse potential?	No change	N/A	High	4Q02	High
Improved safety profile compared to opioids including: - less GI motility impairment - less respiratory depression - low tolerance potential - no dependence/ withdrawal	No clinically significant tolerance, dependence or withdrawal In contrast to opioids, no constipation or respiratory depression liability Tolerability comparable to currently used neuropathic and chronic nociceptive pain products	Simplify profile to focus on the most commercially important AEs Need to be well-tolerated to sell in crowded market with many alternatives	Medium	2Q01	High
	Very few abnormal LFTs	Abnormal LFTs in a few Phase I subjects	High	9/99	High
	Very low nausea/vomiting at effective dose as this condition should be absent in the absence of opioid exposure, e.g.	Incidence of nausea/vomiting in single dose Phase I & II subjects (food and dose dependent) similar to opioids	Low	9/99	High

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	or possible ... a 30 minute duration ... 30 minutes ... generally ... after				
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Table C.2.1. ABT-594 Target Profile (cont.)

PFCC/DDC Profile (12/10/97)	Current Profile (8/00)	Rationale for Profile Change	Probability	Status	Share Impact
	Other safety OK	Simplify profile	Medium	9/99, 2Q01	High
	No significant or sustained differential efficacy in nicotine users vs. non-nicotine users	No difference seen in efficacy to date	High	9/99, 2Q01	Med
	No restrictions for use in nicotine users	Lower incidence of AEs in nicotine users in Phase II trial	High	9/99, 2Q01	Medium
	No re-initiation of cravings in ex-nicotine users	Possible due to nicotine mechanism	Medium	2Q01	High
Onset of action in less than 30 minutes	Onset of action at 1.5 to 2 hours	Onset of action estimated at 90 minutes in Phase II trial	Low	9/99	Medium
BID/TID dosing	BID/QD dosing	Competitive dynamics highlight importance of dosing convenience	High	9/99	Medium
No major drug interactions, especially with drugs used for common chronic conditions	No change	N/A	High	4Q00	Medium

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C.2.2 Target Product Label Brucer: not sure if I was supposed to do this but thought I'd add some key points - I'd like to review in its entirety when technical sections completed, if I may.

Label Requirement	Desired Label claim/ Minimally Acceptable Criteria for a Commercially Viable Product/Competitive Advantage	Regulatory Requirements	Studies/Activities/Other strategy to Achieve
DESCRIPTION			
Formulation	odorless, tasteless, tablet or capsule - small, easy to swallow, marketable color		
Dose form			
Dose strength(s)			
Route of Administration	oral (or patch?) is oral suspension a possibility? - something to consider for elderly population...		
CLINICAL PHARMACOLOGY			
MECHANISM OF ACTION (MUST INCLUDE)	acts on neuronal nicotinic receptors, a subset of cholinergic receptors.... (then something pharmacologic to substantiate lack of addictive quality if possible)		
Pharmacodynamics			
Pharmacokinetics	If favorable (ie: if we are similar to Celebrex) include table like table 1 in Celebrex PI		
Absorption/Bioavailability			
Distribution			
Protein binding			
Distribution			
Metabolism			
Elimination			
Special Populations			
Effect of age	ideally none, downward dose adjustment in elderly okay		
Effect of gender	none		
Effect of race	none		
Use in pregnant women	preg category c (no worse!)		
Use in Nursing Mothers			
Effect of concomitant disease	ideally none		

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Plasma Levels and clinical effect	best not to elucidate unless necessary		
• Effect of food on absorption	very likely NONE		
Clinical Trial Data (by indication)	Neuropathic pain: APT-594 has demonstrated significant reduction in neuropathic pain (+/- time to onset of relief if positive) (diabetic neuropathy and others?) as demonstrated by changes in Likert pain scales. But any secondary measures (other pain scales, such as subjective scores, effect on daily activity, well-being, and other QOL measures (SF36 or others), ?mobility measures?). Any chance of 'stiffness' or ?strength improvements? (even if not direct....)		
Phase 3 studies	"Special Studies": gastrointestinal monitoring -- endoscopic tracking vs. ibuprofen		
INDICATIONS AND USAGE	Indicated for the treatment/relief of neuropathic pain (associated with diabetic neuropathy (alone or with others?)) Potentially OAT		
Clinical Trial Data (only for one indication, the rest in C.P.)			
CONTRAINDICATIONS			
CONTRAINDICATIONS			
WARNINGS			
Black box warnings	NONE		
General Warnings (e.g., thrombocytopenia)	None?		
Usage in Pregnancy	not important		
PRECAUTIONS			
General			
Information for Patients			
Lab Tests			
Drug Interactions	NO CLINICALLY SIGNIFICANT INTERACTIONS with common diabetes drugs, psychotropic drugs, antihypertensives, anticholinergics/lipid lowering agents, NSAIDs, COX-2s, aspirin		
Drug/Lab Test Interactions	NONE with HbA1c		
Carcinogenesis			
Mutagenesis			
Impairment of Fertility			
Pregnancy			
Nursing Mothers			
Pediatric			
Geriatric			
ADVERSE REACTIONS			

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Controlled Phase III study data (by indication)	Nausea < 8%, dyspepsia < 10%, vomiting < 3%, abdominal pain < 5%, diarrhea < 3%, dizziness < 3%, as the agent/combination numbers reflect weight gain < 2%, fatigue < 2%, somnolence < 2%, ataxia < 2%, tremor < 2%, other CNS < 2%, anti-cholinergic effects < 2%		
Other patient populations			
OVERDOSAGE			
DOSAGE AND ADMINISTRATION			
By indication (dose/level/length of treatment)			
Monitoring of Patients *			
General dosing advice			
HOW SUPPLIED			
HOW SUPPLIED			

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C.2.3 Desired Promotional Claims

Table C.2.2 below, outlines the minimally acceptable criteria for a commercially viable product for ABT-594. Items in shaded boxes are NOT FUNDED.

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C.2.2. Desired key messages should follow.

Desired key message	Regulatory milestones	Milestones	Timing	Study Number	Type of milestone	Probability	Time impact	Comments/Notes
Significantly reduce pain associated with diabetic neuropathy	At least 2 adequate, well controlled studies	11 point Likert pain intensity	Launch	Phase III studies (TBD)	Efficacy	Medium	High	
Efficacy and tolerability comparable to gabapentin in the treatment of pain	At least 1 adequate, well controlled, randomized study	First of two pain scales: ODI-17 and NRS (TBD) (if available)	Within 1 year of launch	Phase IV (TBD)	Efficacy, tolerability, patient satisfaction	Low	High	High risk but may be necessary to establish efficacy and tolerability in this population
Significantly reduce pain associated with osteoarthritis	At least 2 adequate, well controlled studies	WOMAC, 4-point categorical pain intensity	Launch or ASAP II launch with neuropathic pain indication	Phase III studies (TBD)	Efficacy	Medium	High	
Efficacy and tolerability comparable to COX-2 inhibitors in OA	At least 1 adequate, well controlled, randomized study	Appropriate pain scale: ODI-17 and NRS (TBD) (if available)	Within 1 year of launch	Phase IV (TBD)	Efficacy, tolerability, patient satisfaction	Low	High	High risk but may be necessary to establish efficacy and tolerability in this population
No clinically significant tolerance, dependence or withdrawal	Phase III/IV trials, specialized addiction studies	AE reports, specific addiction measures	Launch	All studies	Safety	Medium	High	
Well tolerated in comparison to in contrast to opioids, with no constipation or respiratory depression liability	Phase III/IV trials	AE reports	Launch	All studies	Safety	Medium	High	

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Mediated key message	Underlying evidence	Message	Timing	Study format	Type of message	Probability	Share expected	Comments/Risks
Competitive rate of nausea and vomiting given level of efficacy. Well tolerated in comparison to commonly used pain medications.	Phase III trial	AE reports and efficacy measures	Launch	All studies	Safety	Medium	High	
Easy to use with BID/QID dosing and minimal titration	Phase III trial, market research	Study protocols, patient surveys, MD market research	Launch	All studies	Convenience and compliance	High	High	
Cost effective	Phase III and IV	Pharmacoeconomic data	Launch or shortly thereafter	TBD	Cost	Medium	Medium	Important for MG formulary acceptance
Higher patient satisfaction than other comparable medications	Phase III and IV	Survey, CoL measures (HEDIS if available)	Launch or shortly thereafter	TBD	Satisfaction	Medium	Medium	
No clinically relevant drug interactions	Preclinical, Phase I, II, III trials	Clinical and pre-clinical measures?	Launch	All studies	Safety and convenience	Medium	Medium	
Safe for long term use	Phase III extension	AE reports	Following launch?	TBD	Safety	Medium	Medium	

¹HEDIS: Health Plan Employer Data and Information Set; developed by NCQA (National Committee for Quality Assurance) for Managed Care Organization accreditation.

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C.3 Pricing/Reimbursement StrategiesDeleted: [Andrea/Laura to review]
REORDERED**C.3.1 Pricing Strategy [Andrea/Laura to complete]****a. U.S.**Deleted: and European
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The Pain Market's overall pricing in the U.S. market will remain relatively stable in the short term due to two factors. First, the effect of higher-priced branded products entering the market in each analgesic class is tempered by the loss of patent protection of other branded products, and the resulting price erosion due to generic competition. Secondly, the large size of the prescription pain market, and the large number of product offerings in each class, tends to absorb the impact of individual products' prices.

The tremendous success of the COX-2 launches in the U.S. with prices higher than their competition, demonstrate the low price elasticity of demand of the U.S. pain market. Celebrex and Vioxx sell at a 50% premium over other branded anti-arthritis drugs and offer only modest gains in safety. In the neuropathic pain market, Neurontin, with costs per prescription similar to the COX-2s, is seeing continued growth despite the low cost, effective alternative offered by the TCAs. Here again, Neurontin is perceived as offering improvements in safety and tolerability over its generic competition. The unmet need for effective analgesics with improved safety profiles, coupled with the increasing sensitivity regarding aggressive pain treatment contribute to this market dynamic.

Pricing new, and particularly novel, products at a reasonable premium will likely continue to be the norm in the years leading up to the launch of ABT-594. Current forecast assumptions put the price of ABT-594 at a level comparable to Celebrex and Neurontin, grown at a modest 2%/year to launch year AWP of approximately \$95 for a 30 day prescription.

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Pricing for pain medications in US have traditionally been 50% of US prices. Both the COX-2's and gabapentin were introduced at significant price premiums relative to other pain medications. In the countries where the COX-2s have launched, they are priced approximately 20% higher than unbranded and approximately 100% higher than branded sold standards like naproxen and diclofenac. Penetration of the COX-2's has been rather limited thus far - only \$175MM in the US

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markets. This is partially due to delayed launch relative to the US (COX-2s have not yet launched in Japan and many markets in Europe). It may also be due to significant price premiums, which physicians may not feel is justified for the relative modest increases in safety. Neurontin is priced at almost a 2X premium vs. the COX-2's (\$1.2 vs. \$1.0/day), but is comparably priced to the newer anti-seizure drugs. The relatively low penetration of Neurontin in either neuropathic pain or other uses (only \$105MM in ex-US retail pharmacy sales after 5 years on the market) may also be due a low perceived improvement relative to less expensive gold standards.

New pain medications will need to demonstrate a true advantage in efficacy and/or side-effects to receive regulatory approval, especially by the FDA, assuming the target efficacy and tolerability profile of ABT-594 is achieved. ABT-594 would achieve such an advantage. Because ABT-594 may have application in both neuropathic and chronic nociceptive pain, the ex-US pricing assumption for ABT-594 is comparable to COX-2 pricing. The current average price for COX-2's is approximately \$1.10 per day; however, this reflects a large percentage of sales in "free-market" countries which tend to have higher than average prices. Therefore, the average ex-US price is assumed to be approximately \$0.90/day.

C.3.2 Reimbursement/Managed Care

In 1999, 40% of anti-arthritis prescriptions were covered by managed care and 15% by Medicare/Medicaid. A significantly higher percentage, 35%, of COX-2 prescriptions were covered by the government plans, with managed care covering about 30% of the prescriptions for this class. The continued entry of higher-priced, novel analgesics may create some upward trend in prescription analgesic prices over the next 5 years; reaction from government and managed care payors to rising costs could then create pressure to contain costs. However, while managed care and the government will likely pay increasing attention to this market as costs rise, strong efforts to restrict coverage of safer, novel analgesic alternatives are difficult to imagine given the large portion of elderly and disabled in the pain population and the potential for serious backlash to such an unsympathetic stance.

As is now standard in the industry, some level of managed care organization (MCO) rebating for ABT-594 will be necessary. Rebating may be kept below 15% due ABT-594's novel mechanism of action and a potentially unique indication for neuropathic pain; significant discounting may be needed for deep penetration of the broader chronic pain market. The current forecast assumes fairly standard discounts of approximately 15% for managed care and 35% for Medicaid/Medicare.

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Due to the competitiveness of the pain management market and the standard expectations of MCOs, ABT-594 must still favorably complete outcomes and pharmacoeconomic studies in order to gain significant formulary acceptance and use in MCOs and institutional settings. Marketing research and consultation with the PPD Managed Care department will help determine the appropriate number of studies, comparators and desired endpoints. Inclusion of these measures into Phase III trials is key for the early acceptance and success of this product.

Table C.3.1. Pricing/Reimbursement Strategies		
Pricing Strategies	Strategy to Achieve	Requirements/Status (i.e. met or unmet)
US <ul style="list-style-type: none"> Price at level comparable to COX-2s/Neurontin (leading, novel branded products in OA/RA and neuropathic pain markets respectively) 	<ul style="list-style-type: none"> Quality of life and pharmacoeconomics end points in Phase III studies Pharmacoeconomic model Head-to-head comparator trial demonstrating improved QOL, efficacy, and/or cost savings First in class 	<ul style="list-style-type: none"> Unmet Unmet Unmet Unmet
Europe <ul style="list-style-type: none"> Price at level comparable to COX-2s/Neurontin (leading, novel branded products in OA/RA and neuropathic pain markets respectively) 	<ul style="list-style-type: none"> Quality of life and pharmacoeconomics end points in Phase III studies Pharmacoeconomic model Head-to-head comparator trial demonstrating improved QOL, efficacy, and/or cost savings First in class 	<ul style="list-style-type: none"> Unmet
Japan <ul style="list-style-type: none"> Price at level comparable to COX-2s/Neurontin (leading, novel branded products in OA/RA and neuropathic pain markets respectively) 	<ul style="list-style-type: none"> Quality of life and pharmacoeconomics end points in Phase III studies Pharmacoeconomic model Head-to-head comparator trial demonstrating improved QOL, efficacy, and/or cost savings First in class 	<ul style="list-style-type: none"> Unmet

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C.4 Sales Forecast(s) for ABT-594

C.4.1 U.S. Sales Forecast

The U.S. sales forecast for the neuropathic and chronic persistent pain market is shown in Table C.4.1, below.

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Table C.4.1 U.S. Forecast (Date of Forecast: 7/00)					
	2004	2005	2006	2007	2008
Chronic Persistent Nociceptive (OA)	36.6	36.8	37.0	37.2	37.4
Market Rxs (MM)	0.5%	0.5%	0.5%	0.5%	0.5%
- % chg					
Neuropathic Market Rxs (MM)	10.7	11.3	11.8	12.4	13.0
- % chg	5%	5%	5%	5%	5%
Abbott Share CPN(%)	1%	3%	6%	8%	10%
Abbott Share NP(%)	4%	8%	12%	16%	20%
Abbott Rxs CPN(000)	328	1,051	2,220	2,976	3,738
Abbott Rxs NP(000)	427	903	1,418	1,986	2,606
Price/Rx (WAC) (2%/year increase)	\$77.60	\$79.15	\$80.70	\$82.30	\$84.00
Abbott Sales (\$MM)	\$53.1	\$140.1	\$246.4	\$342.6	\$446.9
R&D (\$MM)	\$18	\$8	\$3	\$3	\$3
SG&A (\$MM)	\$67.9	\$63.2	\$66.3	\$60.6	\$58.3
MM (%)	\$51.5	\$136.0	\$239.3	\$333.0	\$434.6
Div. Margin (\$MM)	(\$27.7)	\$66.6	\$168.7	\$267.1	\$370.0

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10 year pre-tax NPV @ 12.5% = \$720 MM

10 year after-tax NPV @ 12.5% = \$427 MM

Key forecast assumptions:

- NDA Filed 5/03, Launch 5/04
- First Neuronal Nicotinic Receptor compound for pain to market
- Indicated for treatment of neuropathic pain; significant publication, or indication, from large scale trial on use in some form of chronic persistent nociceptive pain (e.g.: OA) in 2006
- Efficacy equal to gabapentin, ibuprofen
- Good tolerability and safety profile; comparable to gabapentin, COX-2s ~~and I don't think I have model assumed tolerability equal to COX-2's. Safety vs. tolerability no. "Very low nausea/vomiting at effective dose" is stated in the current profile, which should probably be changed to "nausea/vomiting no worse than mild opioids, e.g., oxycodone."~~
- No addictive potential
- Titration of 3-5 days
- Peak share 20% in neuropathic pain, 10% in chronic, persistent nociceptive pain (including off-label, 'spillover' prescriptions)
- Significant promotional and PR spend in early years
- Physician targets: D6-10 Neuros, D3-10 Rheumatologists/Endocrinologists, D9-10 PCPs
- Sampling at 80% of details at launch, 5 units per detail, 7 days of therapy per unit.

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- Cost comparable to Neurontin and Celebrex
- Significant payor discounting
- Stocking at 8% of first year's sales
- Patent expires 12/2016

Forecast Update Plan:

Forecast will be updated pending analysis of Phase IIb clinical trial results (March or April 2001) or before if the clinical trial plan changes from current assumptions. In late June/early July 1999 to account for revised indications of OA and/or neuropathic pain and the associated spillover use in other pain states. Forecast will be available well in advance of ABT-594 Go/No-Go decision in 9/99.

C.4.2 Ex-U.S. Sales Forecast

The Ex-U.S. sales forecast is shown in Table C.4.2, below.

	2004	2005	2006	2007	2008
Crude Oil Customs Refinement (CPR) Fee (MM)		70.8	71.0	74.3	74.7
% of oil		0.3%	0.3%	0.3%	0.3%
Noncrude Oil Marine Fee (MM)		38.3	43.6	45.2	50.1
% of oil		0.2%	0.3%	0.2%	0.3%
Abuse Share (CPR) (%)		2%	4%	4%	4%
Abuse Share (NP) (%)		4%	8%	12%	16%
Abuse Share (CPR) (%)		1.1%	2.2%	3.5%	3.5%
Abuse Share (NP) (%)		2.5%	2.5%	6.2%	6.6%
Price/fee (30 day) (\$/bbl)		\$21.0	\$27.6	\$27.0	\$27.5
Abuse Sales (\$/bbl)		\$0.0	\$1.0	\$2.1	\$3.1
NOI (\$/bbl)	\$12	\$2	\$2	\$3	\$2
NOI-A (\$/bbl)		\$25	\$25	\$25	\$25
NOI-B (%)		97%	97%	97%	97%
Exp. Margin (\$/bbl)	(\$12)	(\$21)	\$41	\$106	\$148

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			2006	2007	2008
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= \$428
Deleted: 10 year post-tax NPV @
12.5% = \$253
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Key assumptions:

- Same profile and peak share assumptions as U.S. forecast
- Price (ASP) = \$0.50 per day, or \$27 per 30 day Rx (comparable to COX-2 pricing)
- Average AI launch assumption is Q1 2005 to allow for additional regulatory filings (COFS and national filings in FAA and LA) and/or pricing negotiations (most markets in Europe) required in AI markets

- Deleted: First in class COX-2
- Indicated for treatment of moderate to moderately-severe pain
- Effective in neuropathic pain
- Good tolerability and safety profile
- No nicotine-effects (impossible as there wouldn't work) No addictive potential
- Launched in all AI regions, including Japan, simultaneously (2003)

Forecast Update Plan:

Forecast will be updated pending analysis of Phase 1b clinical trial results (March or April 2011) or before if the clinical trial plan changes from current assumptions.

C.4.3 Global Sales Forecast

The global sales forecast is shown in Table C.4.3, below.

	2004	2005	2006	2007	2008
U.S. Sales (\$MM)	\$53.1	\$140.1	\$246.4	\$342.6	\$446.9
Ex-U.S. Sales (\$MM)	\$50	\$80	\$130	\$221	\$313
Total Sales (\$MM)	\$53	\$220	\$376	\$563	\$759
Total Company? Margin (\$MM)	\$250	\$44	\$119	\$272	\$228

10 year pre-tax NPV @ 12.5% = \$1.1MM
10 year post-tax NPV @ 12.5% = \$0.8MM

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C.5 Facilitating Launch and Market Penetration

ABT-594 will hopefully be the first neuronal nicotinic receptor drug to market presenting both opportunity and hurdles. Significant pre-launch activities aimed at increasing understanding of NNR drugs and countering any concerns regarding their association to nicotine will be needed. A comprehensive communication plan will be needed and is discussed in detail below. Research to ensure in-depth understanding of the changing analgesic market and ABT-594's optimal position within that market will need to be conducted periodically up to launch. Opinion leaders in NNR science, general pain management, osteo and rheumatoid arthritis, and diabetic and other neuropathies will be important in the peri-launch period as spokespeople and educators and need to be kept up to date on activities throughout ABT-594's development. These and additional activities to facilitate launch are outlined in Table C.5.1 below.

C.5.1 Activities to Facilitate Launch and Market Penetration	
ACTIVITY	PURPOSE
Pain Specialist Advisory meetings	Permits up to date knowledge of market science and pain treatment trends while building base of supportive, receptive opinion leaders with in-depth knowledge of ABT-594 (and entire neuronal nicotinic receptor program)
Medical education	Primes market with information regarding advances in pain management and introduces neuronal nicotinic receptor class to speed market familiarity and uptake
Information dissemination to publishers	Allows for discussion of class to be included in texts, professional newsletters, pharmacy alerts, etc. to build awareness and understanding of technology (NNR) pre-launch
Managed Care Director Advisories/Roundtables	Allows Abbott to gain understanding of reimbursement environment for pain products, key data that MCOs will need for formulary decisions to potentially include in Phase III clinical trial design
Publication of NNR and ABT 594 specific data at key meetings and in professional journals	Prime market with information regarding advances in pain management and introduce neuronal nicotinic receptor class to speed market familiarity and uptake
Public Relations Activities (media releases, etc.)	Increase general public's comfort level of nicotinic nomenclature particularly regarding the safety and lack of addictive potential for these drugs; may also generate excitement and pull-through demand
Market Research	Determine key drivers of pain prescribing, critical data points, entry niches, and compelling key messages

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C.5.2 Communication Strategy

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A comprehensive communication strategy for ABT-594 as a stand alone product and as the first product of the neuronal nicotinic receptor (NNR) class is in development. Due to the importance of the entire NNR program, a specialized communications strategy vendor (Ingenix) will be working with the internal ABT-594 team to craft the plan. The overall NNR program strategy will be focused on maximizing the market potential for ABT-594 and other compounds by:

- positioning these agents as novel, effective and safe
- generating awareness and educating prescribers and consumers about the NNR class and ABT-594 specifically
- establishing Abbott as the market leader in NNR science

Key to success of this strategy will be the cohesive, coordinated, and aligned efforts of R&D, commercial and public affairs. NUDR Discovery, the Analgesia Venture, NPD, AI NPP, and Public Affairs will work together with the vendor to lay out comprehensive Scientific, Marketing, and Public Relations plans that will outline communication timing, content, audience, and venue for all ABT-594 data. The primary goals of the communication strategy will be:

- position Abbott as the leader in NNR drug development
- augment internal development efforts
- build a base of supportive opinion leaders
- allay consumer concerns regarding the association of these compounds with nicotine
- build a framework for NNR product positioning
- generate market awareness for upcoming product launches

A complete communication strategy publication will be prepared during the third quarter of 2000.

H.5 Patent Issues [Andrea/Jim S. to review] getting copy of patent to consider if we need to explore expanding its scope.

A notice of allowance has been obtained from the United States Patent and Trademark Office on an application providing generic coverage for ABT-594 and a large class of structurally related analogs. The original filing date for this application dates back to October 9, 1992, and since this predates a 1996 change in patent law, we are afforded a choice of 20 years from date of filing or 17 years from date of issue, of which 17 years from issue provides the longer patent life. The anticipated expiration of patent coverage for composition of matter for ABT-594 will be June, 2016. An additional application (6013.US.01), which includes species claims to ABT-594 as well as use claims for the treatment of pain, was filed in December, 1996 and is pending. If this patent is allowed, it will provide 20 years from date of filing, which will extend the patent life of ABT-594 to December, 2016.

24

The original application providing generic composition of matter coverage was filed broadly ex. U.S. (WO94/08992) and this application published on April 28, 1994. A second foreign filing (WO96/40682) published on December 19, 1996. These cases are all still pending.

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ABBT0161968

Addenda

1.1 Highlights re: ABT-594

1.2 Historical Changes to ABT-594 Target Product Profile

- At PPCC, indications considered for ABT-594 were acute vs. chronic pain, with an acute pain claim being considered to have a shorter development course (if long term toxicology studies were not required).
- The FDA (3/98) related their concern that an oral dosage form may be used for chronic therapy even if labeled for acute. Long term toxicology would be required, therefore, even for acute claims.
- Decision analysis review of the program (3/98 - 7/98) arrived at several conclusions:
 - A general pain indication associated with a longer development cycle had greater value than an acute indication associated with a shorter development cycle.
 - Carcinogenicity studies should be initiated prior to first Phase II results.
 - Follow-on compounds (in the same cholinergic channel modulator class and in different pharmacologic classes) should be developed.
- Data from the first Phase II study (single dose molar extraction) indicated that ABT-594's onset of action is 1.5 - 2 hours post dose. Because a general pain indication requires efficacy in acute pain states (with more rapid onset of action), ABT-594 was considered unlikely to achieve a general indication. The current clinical plan targets disease-specific chronic pain indications.

The global target indications for ABT-594 are for the treatment of pain associated with diabetic neuropathy and for the treatment of pain with osteoarthritis.

Landsberg Dep. Ex. 10 / PLs' SM



Bruce
McCarthy /LAKE/PPRD/ABB
OTT
10/03/2000 08:04 AM

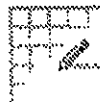
To: Andrea Landsberg/LAKE/PPD/ABBOTT@ABBOTT
Robert J Welland/LAKE/PPD/ABBOTT@ABBOTT,
Rosemarie K Waleska/LAKE/PPD/ABBOTT@ABBOTT,
Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
cc: George W Carter/LAKE/PPRD/ABBOTT@ABBOTT, Mike
Williams/LAKE/PPRD/ABBOTT@ABBOTT, James
Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Larry L
Lin/LAKE/PPD/ABBOTT@ABBOTT

bcc

Subject: Re: ABT 594/963 Purdue meeting

No problem from my perspective. As far as co-development, I think there are some exciting possibilities with Purdue (financials aside). My expectation is that Purdue should be very sophisticated in terms of product development (commercial and clinical) for the chronic pain market. In addition, Lynn Kramer (now VP of Neuroscience there, formerly of Novartis) has extensive neuroscience/pain drug development experience and Curtis Wright (heads up neuroscience/pain development there, formerly of the FDA) has defined the regulatory requirements for pain drugs. Curtis may be a little bit of an unknown variable, though. Although he is the Paul Leber for pain, he has jumped around a bit since leaving the FDA. There may not be a guarantee that he'll stay at Purdue for long. In any event, if we meet with Purdue, I think we should very carefully test their knowledge from a commercial and development perspective.

Andrea Landsberg



Andrea Landsberg
10/03/2000 07:32 AM

To: Robert J Welland/LAKE/PPD/ABBOTT@ABBOTT
cc: Rosemarie K Waleska/LAKE/PPD/ABBOTT@ABBOTT, Christopher J
Silber/LAKE/PPRD/ABBOTT@ABBOTT, Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, George W
Carter/LAKE/PPRD/ABBOTT@ABBOTT, Mike Williams/LAKE/PPRD/ABBOTT@ABBOTT, James
Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Larry L Lin/LAKE/PPD/ABBOTT@ABBOTT
Subject: ABT 594/963 Purdue meeting

Bob,

As you, Rose and I had discussed, if we move forward to set up a presentation of information to Purdue, the following people could probably do the presenting on key topics

Predclinical ABT 594:	Jim Sullivan
Clinical ABT 594:	Bruce McCarthy
Predclinical and Clinical Plan ABT 963:	George Carter
Market Opportunity/Business Rationale:	Andrea Landsberg

If anyone has objections or would like to suggest alternate individuals, please feel free to do so

One final comment that I neglected to bring up yesterday: George and I have had a number of conversations regarding the meaning of 'co-development' and the potential impact on development costs and timelines. I think this needs to be the topic of a separate discussion so that we can clearly define 'co-development' on our terms prior to any negotiations with a partner. Of course, Chris and the analgesia venture's input would be key in this discussion

Andrea

Landsberg DEP. EX. NO. 10
FOR ID.. AS OF 2-16-07 *ML*

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Landsberg Dep. Ex. 11 / PLs' DG



Andrea
Landsberg /LAKE/PPD/ABBO
TT

10/27/2000 12:57 PM

To: Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
rosemarie.waleska

cc

bcc

Subject: 594 Leiden presentation

Here is a first draft of the 594 slides; you will see that there are a few pieces of information that I do not have available with me on the road but will fill in when back in the office. Please provide any comments/suggestions that you have.

Thanks,
Andrea

I am beginning work on the ABS/NPS slides now!



leiden presentation - Nov

Landsberg DEP. EX. NO. 11
FOR ID., AS OF 2-16-07 BC

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ABBT0116819

ABT 594 for Neuropathic Pain Commercial Overview

Andrea Landsberg
Laura Robinson



Pain Markets Considered for ABT 594

- Acute and chronic pain
- Chronic pain
 - nociceptive and neuropathic
- OA/RA
- Neuropathic pain
 - diabetic polyneuropathy pain
- Moderate to moderately severe pain

ABT 594: Current vs DDC Profile

DDC Profile (227)	Current Profile (940)
<ul style="list-style-type: none"> • Indicated for the treatment of pain (general pain claim) • Improved safety profile compared to opioids including: <ul style="list-style-type: none"> • less GI motility impairment • less respiratory depression • less tolerance potential • no dependence/withdrawal • No titration • Onset of action in less than 30 minutes 	<ul style="list-style-type: none"> • Indicated for the treatment of neuropathic pain; efficacy in OA demonstrated in non-indication trial • In contrast to opioids, no constipation or respiratory depression liability • In DPN, potentially high (>30%) dx confirmation rates due to vomiting • Titration to minimize SEs • Onset of action at 1.5 to 2 hours

Indication and Spillover Potential

- Market research conducted x/99?
- Make table with share% in various markets depending upon indication
- clarify product profile in study vs current knowledge

Neuropathic Pain Market

1999 Key Neuropathic Pain Products, Estimated \$ Sales

Product Class	1999 U.S. Sales (\$MM)	U.S. Sales CAGR 97-99	1999 ex-U.S. Sales (\$MM)	ex-U.S. Sales CAGR 97-99
Neurontin	\$500	21.7%	\$21	17.6%
carbamazepine	\$17	15.1%	\$67	7.5%
TCAs	\$26	3.3%	\$70	N/A
TOTAL	\$583	21.7%	\$149	19.3%

Source: IMS, National Neuropathic Pain Survey. Ex-U.S. data includes retail pharmacy data from all marketed markets.
N/A = not available.

- Projected growth rates over next xx years vary from XXX to YYY
- Sales volume impacted by high use of generics; Pregabalin may significantly grow market sales
- NSAIDS, though not very effective, are also used as first line treatment for neuropathic pain (particularly by PCPs) and are not reflected in above market totals

Neuropathic Pain Competition

Product	Pros	Cons
NSAIDs/COX-2s	Often used first line by PCPs COX-2s increasing comfort with chronic use Generally no expensive except for COX-2s	Generally low efficacy in neuropathic pain
TICAs (amitriptyline, nortriptyline, etc.)	Generally effective Inexpensive	OTC label use Side effects limit use (weight gain, anticholinergic symptoms) Risk of overdose Duration required
Venlafaxine (gabapentin)	Good efficacy, cost found that this treatment Some well controlled positive trials	At least 1/3 of patients may not experience pain relief Duration required, high doses required (high pill burden) TID dosing Expensive, though will be self-pay at time of APT 204 launch Somnolence, dizziness, cognitive side effects Not indicated for pain (except in LHO)
Topiramate	Initial data in neuropathic pain very promising Lower doses than with Neurontin No weight gain Likely no proven indication in pain	TID dosing (less attractive?) Allx as for Neurontin; low DVC rates in trial Two trials in chronic low back pain failed to show significant efficacy

Unmet Needs in Neuropathic Pain

- More complete efficacy than that provided by Neurontin
 - › including increase in responder rate
- Efficacy matching Neurontin, with reduced side effects
- Treatments with reduced or no titration
- Improved dosing schedules, ideally QD
- Formulation options for single compound
 - › patch, parenteral, solution, sprinkle, melt

Potential Positioning of ABT 594 in Neuropathic Pain

- First line therapy:
 - › Improved efficacy over AEDs and TCAs with 'comparable' SEs
 - › Novel therapy approved for neuropathic pain
- Second line therapy
 - › Comparable efficacy and AEs as current therapies for non or partial responders

ABT 594 Forecast

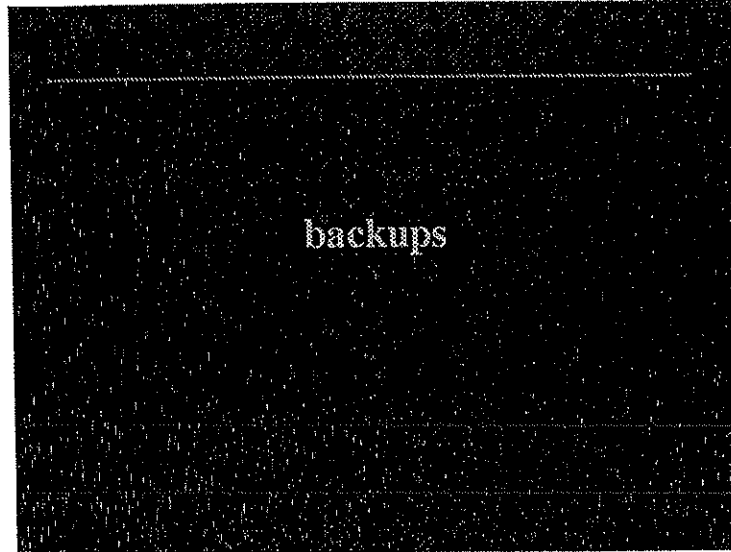
	U.S.	ROW	Total
Peak Sales	\$447 MM	\$xxx MM	\$xxx MM
Peak Share			
Neuropathic	20%	20%	NA
Persistent Nociceptive	10%	10%	
NPV @ 12.5%	\$422 MM	\$215 MM	\$637 MM
(inf. max.)			

ABT 594 Forecast Assumptions

	Os	Row
Indication	Neuropathic pain (published study of efficacy in OA by 2006)	
Key dates	NDA filed 9/03 Approval 2004	
Order of entry	First molecule to market for pain	
Safety	No additional liability No major safety concerns	
AWP/box	\$125	
Dosing	15-150mg BID, 3-5 day titration	
Efficacy	Greater than Neurontin for neuropathic and COX-2 in osteoarthritis	
Tolerability	CNS SAs improved over Neurontin; GI SAs improved over tramadol	
COGS	\$216K/kg (retail potency)	

Key Product Challenges

- Tolerability
 - › Competition has clear advantage on tolerability
 - › Potentially low therapeutic index
 - › PCP market will be particularly impacted
- Nicotinic mechanism
 - › Will require pre-launch market education and priming to both diffuse negative associations and generate excitement (surrounding novel MOA)

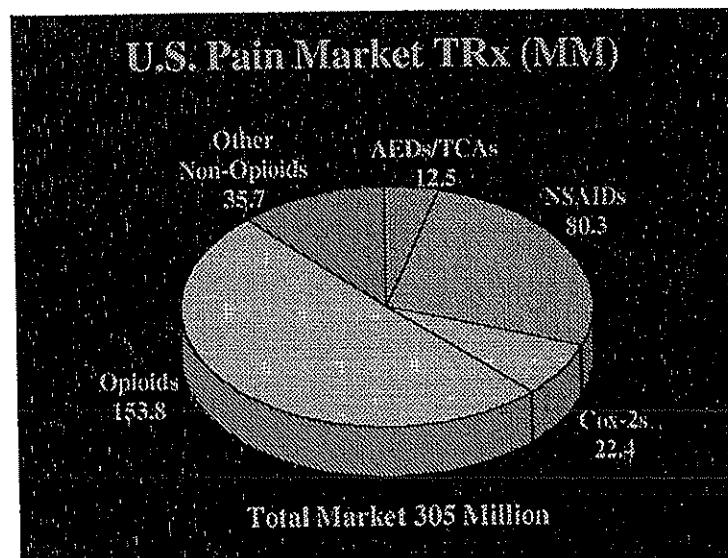


Complexity of Segmenting the Pain Market

- Pain Market can be segmented in a variety of ways
 - Duration
 - Peracute, Acute, Chronic
 - Severity
 - Mild, Moderate, Severe
 - Pathophysiology
 - Neuropathic, Nociceptive, Mixed
 - Etiology
 - Cancer, Injury, Infection, Metabolic (DPN), Immunologic (OA/RA), etc.
- Each classification is relevant for almost every pain patient

U.S. Pain Market Growth 1997 to 1999

	TRx CAGR 97-99	Sales CAGR 97-99
AEDs	26.3%	28.7%
ICAs	8.2%	-3.3%
NSAIDs	-1.3%	-3.9%
Cox-2s	NA	NA
Opioids	2.5%	8.2%
Other Non-Opioids	-1.0%	-3.8%



Landsberg Dep. Ex. 18 / PLs' DS



Michael K
Blarnesen/LAKE/PPRD/ABB
OTT
11/29/2000 02:11 PM

To: Andrea Landsberg/LAKE/PPD/ABBOTT@ABBOTT
cc: Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT
bcc:
Subject: Re: ABT 594 forecast scenarios for BD partnering

Andrea,

Here is what Chris and I worked up for the Label/ Development Cost scenarios. We have included different scenarios, so after you have a chance to review, let's get on the phone and reconcile, OK?

Mike B



ABT-594 Partner.ppt
Andrea Landsberg

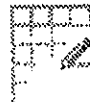
Andrea Landsberg

11/29/2000 10:40 AM

To: Robert J Weiland/LAKE/PPD/ABBOTT@ABBOTT
cc: Larry L Lin/LAKE/PPD/ABBOTT@ABBOTT, Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Michael K Blarnesen/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Rosemarie K Waleska/LAKE/PPD/ABBOTT@ABBOTT
Subject: Re: ABT 594 forecast scenarios for BD partnering

Need to titrate this drug to (any) effective level, therefore that cuts us out of any 'acute' or chronic but intermittent type of use; Oxycontin may need to be titrated to max efficacy and dose may need to be increased if tolerance develops but it still can be given at a dose that is likely to provide some pain relief right off the bat. This has been the thinking since the phase Ila results were in.

Robert J Weiland



Robert J Weiland
11/29/2000 10:13 AM

To: Andrea Landsberg/LAKE/PPD/ABBOTT@ABBOTT
cc: Larry L Lin/LAKE/PPD/ABBOTT@ABBOTT, Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Michael K Blarnesen/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Rosemarie K Waleska/LAKE/PPD/ABBOTT@ABBOTT
Subject: Re: ABT 594 forecast scenarios for BD partnering

Andrea:

This looks like a decent starting point. Oxycontin will do over \$1 billion by itself. I am wondering if our upsides don't take us well over the \$1 billion mark?

BW

Andrea Landsberg

Andrea Landsberg

11/29/2000 07:17 AM

Sandsberg DEP. EX. NO. 18
FOR ID., AS OF 2-16-07 BL

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ABBT0119091

To: Larry L. Lin/LAKE/PPD/ABBOTT@ABBOTT, Christopher J. Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Michael K. Blarnesen/LAKE/PPRD/ABBOTT@ABBOTT, Bruce
McCarthy/LAKE/PPRD/ABBOTT@ABBOTT
cc: Rosemarie K. Waleska/LAKE/PPD/ABBOTT@ABBOTT, Robert J. Weiland/LAKE/PPD/ABBOTT@ABBOTT

Subject: ABT 594 forecast scenarios for BD partnering

I have made some initial slides and forecast estimations that take the 594 forecast up in steps based on potential additional studies. I have done this 2 ways: one starting from the development plan forecast (Mike: the revised one that has the updated NP market size plus the launch delay, not the one in the 'draft' development plan) and one starting one step back from there without any study in a chronic nociceptive pain state. Please let me know ASAP if these steps will be acceptable and whether rough costs for these hypothetical programs can be determined.

Larry, please let me know if these numbers look acceptable -- some of them may already be optimistic -- BD's call as to whether you want to inflate them for 'best case' scenario.

Andrea



BD partnering slide on insides to be

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ABT 594 Forecast Potential

Scenario	Peak Sales (\$MM)
Indication in DPN w/ nociceptive publication	\$507
Above plus additional neuropathic pain states pub	\$629
Above plus opioid sparing publication	\$746
Above plus OA or other nociceptive indication	\$1009

DPN = Diabetic neuropathic pain

ABT 594 Forecast Potential

Scenario	Development Plan Base	Peak Sales (\$MM)
Indication in DPN w/ nociceptive publication <small>20% share NP; 10% CPP</small>		\$507
		+122
Above plus additional neuropathic pain states pub. <small>additional 10% share of NP (total share of 30%)</small>		= \$629
		+117
Above plus opioid sparing publication <small>10% share of 75% of "strong opioid market" (generous)</small>		= \$746
		+263
Above plus OA or other nociceptive indication <small>morphine, synthetic opioid, oxycodone</small>		= \$1009
		+263
		additional 10% share in CPP (total share of 20%) -- optimistic.

NP = neuropathic pain, CPP = chronic persistent (nociceptive) pain

ABT 594 Forecast Potential

Scenario	Peak Sales (\$MM)
Indication in DPN	\$235
Above plus additional neuropathic pain state pub.	\$365
Above plus nociceptive publication	\$628
Above plus opioid sparing publication	\$745
Above plus OA indication	\$1008

ABT 594 Forecast Potential

Scenario	Peak Sales (\$MM)
Indication in DPN	\$235
→ 20% share NP	+122
Above plus additional neuropathic pain state pub.	= \$365
→ additional 10% share of NP (total share of 30%)	+263
Above plus nociceptive publication	= \$628
→ 10% share of CPP	+117
Above plus opioid sparing publication	= \$745
→ 10% share of 75% of 'strong opioid market' (morphine, synthetic opioid, oxycotin) (generous)	+263
Above plus OA indication	= \$1008
→ additional 10% share in CPP (total share of 20%) -- optimistic.	

Indication in DPN → \$235

 → 20% share NP → +122

Above plus additional neuropathic pain state pub. = \$365

 → additional 10% share of NP (total share of 30%) → +263

Above plus nociceptive publication = \$628

 → 10% share of CPP → +117

Above plus opioid sparing publication = \$745

 → 10% share of 75% of 'strong opioid market' (morphine, synthetic opioid, oxycotin) (generous) → +263

Above plus OA indication = \$1008

 → additional 10% share in CPP (total share of 20%) -- optimistic.

Landsberg Dep. Ex. 19 / PLs' EB



Jennifer
Dart/LAKE/PPRD/ABBOTT
12/21/2000 11:35 AM

Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Michael K Biamesen/LAKE/PPRD/ABBOTT@ABBOTT,
Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Andrea
Landsberg/LAKE/PPD/ABBOTT@ABBOTT, Laura
Robinson/LAKE/AV/ABBOTT@ABBOTT, Barbara T
Massa/LAKE/PPRD/ABBOTT@ABBOTT, Steve C
Kuemmerle/LAKE/PPRD/ABBOTT@ABBOTT, George W
Carter/LAKE/PPRD/ABBOTT@ABBOTT, Chris G
Turner/LAKE/PPRD/ABBOTT@ABBOTT
cc Richard J Marasco/LAKE/PPD/ABBOTT@ABBOTT

bcc

Subject Analgesia Internal Review Notes

Thanks to everyone for your participation in the Analgesia Internal Review.

Andrea, Laura or Chris: will one of you please set up some time with Rock to review the project assumptions and forecasts.

As a reminder, final forecasts are due to Chris Turner on Monday, January 15th, although we would greatly appreciate receiving them before then if possible.

Following is the list of follow up items from the meeting:

ABT-594

- Andrea will reduce forecast to reflect vomiting AE
- Osteo project will change name to Chronic Persistent Pain Publication (CPPP)
- Steve Kuemmerle will research whether the CPPP probability of success should be reduced to 16% since this project is contingent upon Neuro Pain project success

ABT-089

- Laura & Andrea to review forecast assumptions
- Need to check COGS estimate
- Probability of success revised to 18%

Hydrocodone -

- Forecasts will be submitted prior to January 1. We can review these forecasts at the ABS/NPS review scheduled for January 10th.
- Rapid Dissolve probability of success reduced to 35% due to RP Scherer DEA import issues

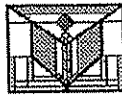
General

- Patent expiration dates need to be confirmed for all compounds
- R&D spending ends at launch

Landsberg DEP EX 19
FOR ID., AS OF 2-16-07 *MC*

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ABBT0108041

Landsberg Dep. Ex. 26 / PLs' EJ



Michael K
Blanesen/LAKE/PPRD/ABB
OTT
02/01/2001 01:11 PM

To Christopher J Silber/LAKE/PPRD/ABBOTT@ABBOTT,
Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT
cc
bcc
Subject Re: financial slides for Leiden meeting 2/2

FYI

Forwarded by Michael K Blanesen/LAKE/PPRD/ABBOTT on 02/01/2001 01:11 PM

Andrea Landsberg

02/01/2001 10:34 AM

To: Thomas E Woldat/LAKE/PPRD/ABBOTT@ABBOTT
cc: Michael K Blanesen/LAKE/PPRD/ABBOTT@ABBOTT
Subject: Re: financial slides for Leiden meeting 2/2

Tom,

As per your request to Mike -- this is not all of the slides that will be shown but just those with financial info -- please let me know if there is anything else you require.

Andrea



ART-089 Leiden Presentation Commercial fin ART-594 Leiden Presentation Commercial fin



ART-089 Port Qual final 1- ART-594 neuropathic pain - ART-594 publication study

Handwritten signature: Landsberg
EX. NO. 26
FOR ID., AS OF 02-16-07

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ABT 594 Global Forecast Ranges

(\$MM)

	Peak Sales		
	Low	Base	High
US	\$92	\$339	\$509
Ex-US	\$130	\$363	\$712

•NP shares: 5%, 20% or 30%
•CPP shares: 3%, 5%, 7%

ABT 594 Global Forecast Ranges

	(\$MM)					
	Peak Sales			NPV		
	Low	Base	High	Low	Base	High
US	\$92	\$339	\$509	\$2	\$313	\$522
Ex-US	\$130	\$363	\$712	\$55	\$356	\$857

ABT 594 Pricing

- US launch price \$3.57/day (AWP)
 - Comparable to Neurontin/Cox 2 daily AWP (in 2004)
 - Should be supportable – one of few drugs indicated for NP and a novel mechanism
 - Forecasting assumes reasonable discounting to ensure MC coverage and penetration
- Ex-US launch price \$0.90/day (ASP)
 - Comparable to premium priced pain drugs (COX-2)
 - Unlikely to match Neurontin price, as ABT-594 will likely be reference-priced vs. analgesics, not AEDs

Used in base case forecast, 1/01

ABT 594 Margin on Per Tab Basis

- $300\text{mcg/tab} = 0.0000003\text{kg/tab}$
- $\text{COGS/kg (including finishing costs)} = \250K
- $\text{COGS on per tab basis} = \0.075
- $\text{Price/tab} = \$1.78 \text{ (US AWP); } \0.45 (Ex-US ASP)
- $\text{Margin/tab} = 96\% \text{ (US); } 83\% \text{ (Ex-US)}$

ABT 594 Promo and Sales Force Spend

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Promo spending (\$MM)	2	30	39	45	50	57	65	75	88	100	110	120	130	140
Direct to Customer spending (\$MM)	0	2	3	4	5	6	7	8	9	10	11	12	13	14
FR spending (\$MM)	2	28	36	41	45	51	58	67	79	90	99	108	117	126
Total Promo spending (\$MM)	2	32	42	49	55	63	72	83	97	110	121	132	143	154
TOTAL PROMO EXPENSE	10	37.8	49.8	57.0	63.0	72.0	82.0	94.0	109.0	125.0	140.0	155.0	170.0	185.0
Sales (\$MM)	150	270	350	450	550	650	750	850	950	1050	1150	1250	1350	1450
% of Sales	6.7%	13.9%	14.2%	12.7%	11.5%	11.1%	10.7%	11.1%	11.5%	11.8%	12.2%	12.5%	12.6%	12.8%

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total Sales Force Expense (\$MM)	1	1	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0

ABT 594 Base Case Forecast

	U.S.	Ex-US
Peak Sales	\$339 MM	\$363 MM
Salesforce/Promo	\$54MM	\$34MM
Peak Share		
Neuropathic	20%	20%
Chronic Persistent	5%	5%
NPV @ 12.5% (after tax)	\$313 MM	\$336 MM

Landsberg Dep. Ex. 28 / PLs' EL

**(See S. Blewitt Affidavit For Complete
Version Of Doc)**

JESSICA HOPFIELD
McKinsey Partner

JOHN HANCOCK'S DEPOSITION DESIGNATIONS

JESSICA HOPFIELD
McKinsey Partner

June 18, 2007

FROM	TO	EXHIBIT
p. 4, l. 2	p. 4, l. 14	None
p. 8, l. 10	p. 12, l. 12	None
p. 16, l. 4	p. 19, l. 12	None
p. 19, l. 22	p. 20, l. 22	None
p. 24, l. 6	p. 25, l. 12	None
p. 39, l. 19	p. 40, l. 22	None
p. 42, l. 20	p. 43, l. 9	None
p. 44, l. 12	p. 45, l. 7	None
p. 46, l. 19	p. 49, l. 7	None
p. 50, l. 1	p. 50, l. 22	None
p. 74, l. 12	p. 75, l. 8	Dep. Ex. 4/ PLs' FC
p. 78, l. 6	p. 81, l. 11	Dep. Ex. 4/ PLs' FC
p. 81, l. 20	p. 82, l. 5	Dep. Ex. 4/ PLs' FC
p. 87, l. 1	p. 89, l. 7	Dep. Ex. 5/ PLs' FH
p. 90, l. 17	p. 91, 20	Dep. Ex. 5/ PLs' FH
p. 95, l. 5	p. 96, l. 12	Dep. Ex. 5/ PLs' FH
p. 98, l. 20	p. 102, l. 15	Dep. Ex. 5/ PLs' FH
p. 103, l. 4	p. 105, l. 15	Dep. Ex. 6/ PLs' GW
p. 107, l. 1	p. 109, l. 4	Dep. Ex. 7/ PLs' FI
p. 110, l. 13	p. 111, l. 21	Dep. Ex. 7/ PLs' FI
p. 116, l. 6	p. 118, l. 1	Dep. Ex. 8/ PLs' FL Dep. Ex. 9/ PLs' FM Dep. Ex. 10/ PLs' FR Dep. Ex. 11/ PLs' FS
p. 125, l. 1	p. 127, l. 12	None
p. 133, l. 24	p. 134, l. 22	Dep. Ex. 8/ PLs' FL
p. 149, l. 18	p. 149, l. 24	Dep. Ex. 10/ PLs' FR
p. 155, l. 2	p. 156, l. 19	Dep. Ex. 11/ PLs' FS
p. 161, l. 5	p. 162, l. 24	Dep. Ex. 10/ PLs' FR
p. 166, l. 2	p. 166, l. 22	Dep. Ex. 11/ PLs' FS
p. 215, l. 4	p. 217, l. 2	Dep. Ex. 5/ PLs' FH

00001

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF MASSACHUSETTS
3
4 JOHN HANCOCK LIFE INSURANCE)
5 COMPANY, JOHN HANCOCK VARIABLE)
6 LIFE INSURANCE COMPANY, f/k/a)
7 INVESTORS PARTNER INSURANCE)
8 COMPANY,)
9 Plaintiff,) 05-11150-DPW
10 vs.)
11 ABBOTT LABORATORIES,)
12 Defendant.)

13

14 The deposition of JESSICA HOPFIELD, called
15 for examination, taken before KATRINA WRIGHT,
16 CSR No. 84-3639, a Notary Public within and for
17 the County of Cook, State of Illinois, and a
18 Certified Shorthand Reporter of said state, at
19 Suite 1300, Two North LaSalle Street, Chicago,
20 Illinois, on the 18th day of June, A.D. 2007, at
21 1:01 p.m.

22

23

24

00004

2 (WHEREUPON, the witness was duly
3 sworn.)

4 JESSICA HOPFIELD,
5 called as a witness herein, having been first duly
6 sworn, was examined and testified as follows:

7 EXAMINATION

8 BY MS. TROAKE:

9 Q. Ms. Hopfield, could you state your full
10 name for the record, please.

11 A. Jessica Hopfield.

12 Q. And your home address?

13 A. 333 West North Avenue, Chicago,
14 Illinois.

00008

10 Q. And, Ms. Hopfield, you are currently
11 employed at McKinsey; is that right?

12 A. Yes.

13 Q. Is that in Chicago?

14 A. Yes.

15 Q. What is your current role at McKinsey?

16 A. I am a principal, which is a
17 designation that means partner.

18 Q. And as a principal at McKinsey, what do
19 you do?

20 A. I have responsibility for leading
21 individual client engagements. I oversee more
22 broadly the relationship we have with our clients.
23 And I play a number of leadership roles in the

24 firm on internal issues.

00009

1 Q. Do you head up any particular practice
2 area?

3 A. Yes. I co-lead our marketing efforts
4 in our pharmaceuticals and medical products
5 practice.

6 Q. And how long have you been responsible
7 for that practice group?

8 A. Two years.

9 Q. So since 2005?

10 A. Yes.

11 Q. Prior to 2005, were you responsible for
12 any other practice group?

13 A. No.

14 Q. When did you become a principal at
15 McKinsey?

16 A. 2001.

17 Q. And did you work at McKinsey prior to
18 2001?

19 A. Yes. I was an associate for five and a
20 half years.

21 Q. And were you assigned to a particular
22 practice area while you were an associate?

23 A. We don't assign, but, yes, I was
24 affiliated with our pharmaceutical and medical

00010

1 products practice.

2 Q. Any other positions at McKinsey, other

3 than an associate and principal?

4 A. No.

5 Q. What did you do prior to joining
6 McKinsey?

7 A. I was at Merck & Company, the
8 pharmaceutical company.

9 Q. And what did you do for them?

10 A. I was in three different roles: in
11 marketing, in clinical development, and in their
12 project planning and management function.

13 Q. How long did you work at Merck?

14 A. Two years.

15 Q. And were you doing each one of those
16 roles during that entire time or did you have each
17 of those roles at different times during that
18 two-year period?

19 A. They were at different times. They
20 were sequential.

21 Q. What did you do prior to joining Merck?

22 A. I was a student at Harvard Business
23 School.

24 Q. When did you graduate from Harvard?

00011

1 A. 1993.

2 Q. And prior to that?

3 A. I was a post-doc at Rockefeller
4 University.

5 Q. Where is Rockefeller University?

6 A. New York City.

7 Q. And prior to that, what did you do?

8 A. I was a Ph.D. student at that same
9 university.

10 Q. Where did you get your undergraduate
11 degree?

12 A. Yale.

13 Q. What was that in?

14 A. In biology.

15 Q. When did you get that degree?

16 A. 1986.

17 Q. Okay. At what point in 2001 did you
18 become a principal at McKinsey?

19 A. I was elected in mid December and that
20 would have been effective, if I remember
21 correctly, the beginning of 2002.

22 Q. So from January to December of 2001,
23 you were an associate?

24 A. I'm sorry. I made an error. I would

00012

1 have been elected a principal in December of 2000.

2 That would have been effective in January of 2001.

3 Q. Okay. Did you supervise other people
4 at McKinsey as the head of the pharmaceutical and
5 medical products group?

6 A. Yes.

7 Q. Who did you supervise during 2001 in
8 that group?

9 A. Well, at that time, I was a member of,
10 as opposed to leading the practice. The people I

11 would supervise would be associates on my various
12 engagement teams.

00016

4 Q. When did you first become involved with
5 the engagement with respect to Abbott
6 Laboratories?

7 A. This would have been late 2000, when we
8 were starting to propose on supporting them
9 overall in the Abbott-Knoll pharmaceutical merger.

10 Q. And who at McKinsey was involved in the
11 services that were provided to Abbott in relation
12 to that engagement?

13 A. That engagement was overall led by
14 Richard Ashley, the individual you mentioned
15 earlier. As what we call our director of client
16 service, that was the most senior partner. David
17 Keeling was a more junior partner at the time who
18 had responsibility for the overall effort. And
19 then there were several other partners involved in
20 specific topic areas.

21 Q. And who were they?

22 A. I was one in R&D. I actually cannot
23 recall the complete set. There was Martin Lutz in
24 Germany, but I cannot recall the rest of the

00017

1 partners involved.

2 Q. What about people other than partners?

3 A. The primary people that I recall were
4 Michael Williams, who was an associate principal

5 at the time -- that's a role right below
6 partner -- who was working on R&D with me. Doane
7 Chilcoat, who we just described before. There
8 would have been assigned to the study a number of
9 associates. I can't recall who they were. But we
10 had a team probably across all of the activities
11 of something like 15 to 20 people. But I had
12 interaction with only a few.

13 Q. And the people you had interactions
14 with, are those the ones that you mentioned or are
15 there others you had interactions with?

16 A. That is the core set.

17 Q. How did you become involved with the
18 engagement of McKinsey by Abbott?

19 A. Richard Ashley was leading the
20 development of our proposal to support them on the
21 merger. It was competitive with another
22 consulting firm, and as part of the what we call a
23 beauty contest, the two companies coming in and
24 describing what they would do, I was pulled in to

00018

1 be an R&D expert. And so I was involved in some
2 of the later meetings as we were getting close to
3 having the engagement confirmed.

4 Q. And do you know when the engagement was
5 confirmed?

6 A. I don't recall, but it would have been
7 in the late 2000, early 2001 timeframe, but I do
8 not recall the date.

9 Q. What was the scope of the services that
10 McKinsey was hired to provide in connection with
11 the Abbott-Knoll integration?

12 A. We were hired to overall manage and
13 co-lead with them the integration of the two
14 companies, which had a number of components, the
15 prime area of which was ensuring Day 1, the day of
16 the new legal entity went smoothly, to help design
17 the new organization in terms of structure, and to
18 coach and counsel the senior executives from both
19 companies through the transition period.

20 Q. Design the new organization, coach and
21 counsel senior management through the transition
22 period --

23 A. And then prepare for Day 1.

24 Q. Okay. Thank you.

00019

1 Do you recall when Day 1 was?

2 A. No.

3 Q. And Day 1 being the first day of the
4 new --

5 A. Legal entity.

6 Q. Do you recall how long the engagement
7 lasted?

8 A. Roughly six months.

9 Q. So if it started in December, January,
10 2000, 2001, it was completed by June or July of
11 '01?

12 A. By June or July.

00019

22 Q. Is McKinsey currently doing any work
23 for Abbott?

24 A. Yes.

00020

1 Q. Are you personally involved in that?

2 A. No.

3 Q. What was your particular role in
4 relation to the services provided by McKinsey?

5 A. My particular role was to lead the R&D
6 work stream.

7 Q. What does that mean, lead the R&D work
8 stream; is that what you said?

9 A. Yeah. Because in a merger there are a
10 lot of functional areas that are impacted. We
11 divided ourselves up into a number of focused
12 teams, both the McKinsey folks and the client to
13 design and organize that function. And my
14 responsibility was to oversee that for R&D.

15 There were similar teams that were
16 working on issues of commercial integration, some
17 of the European sites and a number of other
18 functional or geographic axes. And in that
19 leadership role I had responsibility for leading
20 the work of my team, ensuring that we were meeting
21 our deadlines and overall ensuring the success of
22 that integrated R&D organization.

00024

6 Q. As part of all that work that McKinsey

7 was doing, would you attend regular meetings with
8 the senior management at Abbott?

9 MR. LORENZINI: Objection.

10 BY MS. TROAKE:

11 Q. You can answer.

12 A. Okay. Sorry. Thank you.

13 I would attend project team meetings
14 for the specific engagement.

15 Q. And what is a project team meeting?

16 A. It's a regularly scheduled update where
17 the McKinsey team meets with the leadership that
18 is responsible for the engagement and we talk
19 about how things are going and plan the next few
20 weeks.

21 Q. Is that just McKinsey people or does
22 that include Abbott people, or did that include
23 Abbott people?

24 A. It typically involves the McKinsey team

00025

1 and the handful of Abbott people who are
2 overseeing the specific engagement.

3 Q. And with respect to the Abbott-Knoll
4 integration, how frequently would you have these
5 project team meetings?

6 A. I don't recall for this specific
7 engagement. Typically it's weekly or biweekly.

8 Q. And do you recall who from Abbott would
9 attend the project team meetings in this instance?

10 A. It would be Jeff Leiden, John Leonard,

11 and then a subset of more junior individuals who I
12 do not recall.

00039

19 Q. You also mentioned that you attended
20 what you think was an off-site meeting in January
21 of '01 to kick off the merger; is that right?

22 A. Yes.

23 Q. And do you recall where that meeting
24 was?

00040

1 A. At Abbott Park.

2 Q. And do you recall who attended that
3 meeting?

4 A. There were over 100 people there across
5 both the Abbott and Knoll organizations. It was
6 the formal kickoff.

7 Q. And how long did that meeting last?

8 A. Most of the day.

9 Q. Just one day or more than one day?

10 A. I don't recall.

11 Q. Was there an agenda circulated for that
12 kickoff meeting?

13 A. I don't recall.

14 Q. So there might have been, you just
15 don't remember?

16 A. Correct.

17 Q. Did you ever attend any meetings of the
18 R&D integration steering committee? Does that
19 ring any bells?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. Yes.

00042

20 Q. What was the purpose in having McKinsey
21 present for the January kickoff meeting, do you
22 know?

23 MR. LORENZINI: Objection.

24 BY THE WITNESS:

00043

1 A. Since we had overall responsibility for
2 helping ensure the success of the integration
3 process, as part of that, we had a role in
4 designing that kickoff, facilitating portions of
5 it.

6 Richard Ashley gave one of the keynote
7 addresses, and we were asked to be there and help
8 to begin, in some sense, the cultural integration
9 of the two organizations.

00044

12 Q. In the course of the consulting
13 arrangement, were you or anyone at McKinsey
14 provided with documents from Abbott about its
15 portfolio and its compounds?

16 A. Yes.

17 Q. What kinds of documents were you
18 provided? When I say "you," I mean you personally
19 and anyone at McKinsey.

20 A. I don't recall specifics of the

21 documents, but I do recall that we would have
22 received a number of materials such as
23 organization charts of the R&D sites, lists of the
24 R&D Abbott budgets, a description of the compounds

00045

1 by pipeline phase, and in some cases, a few deeper
2 dives into a specific product, if that were
3 relevant to some site or personnel decision.

4 Q. What do you mean by "deeper dives"?

5 A. It would be a -- typically a 15- or
6 20-page document that would talk in more detail
7 about the compound, how it was being developed.

00046

19 Q. Was it part of McKinsey's role in its
20 arrangements with Abbott to make any
21 recommendations about how particular compounds
22 should be developed or whether a particular
23 compound should continue to be developed?

24 MR. LORENZINI: Objection, form.

00047

1 BY THE WITNESS:

2 A. No.

3 BY MS. TROAKE:

4 Q. Was it part of McKinsey's role and
5 responsibilities to assist Abbott and, I guess, to
6 a certain degree, Knoll in terms of the
7 integration to assist them in deciding how to --
8 which compounds would be developed going forward?

9 MR. LORENZINI: Objection to form.

10 BY THE WITNESS:

11 A. Yes.

12 BY MS. TROAKE:

13 Q. And in terms of assisting them and
14 making those kinds of decisions, what precisely
15 would McKinsey do? What kind of work product or
16 deliverables would you provide?

17 MR. LORENZINI: Objection, vague.

18 BY THE WITNESS:

19 A. Our responsibility was to ensure that a
20 meeting was designed that had the relevant parties
21 in the room and that they were prepared to have an
22 overall conversation, so it was really to create
23 the conditions for them to have the conversations
24 they would like to have.

00048

1 BY MS. TROAKE:

2 Q. And was that meeting the March 2001
3 off-site meeting that you referred to previously?

4 MR. LORENZINI: Objection.

5 BY THE WITNESS:

6 A. Yes.

7 BY MS. TROAKE:

8 Q. So, specifically with respect to that
9 off-site meeting, can you describe for me in more
10 detail your best recollection as to what McKinsey
11 did precisely?

12 MR. LORENZINI: Objection to form.

13 BY THE WITNESS:

14 A. My recollection is that I talked with
15 Joe Nemmers and Jeff Leiden beforehand to discuss
16 how to best design the several datas to ensure
17 that the groups had an effective interaction. I
18 helped design the agenda. And discussed with them
19 also what format the presentations should come in
20 since this was the first time that some of the
21 individuals had had a chance to present data to
22 Abbott. And so we wanted consistency across the
23 various presentations.
24 BY MS. TROAKE:

00049

1 Q. Anything else?
2 A. No.
3 Q. Do you recall how much Abbott paid
4 McKinsey in relation to the consulting arrangement
5 for the Knoll integration?
6 A. Overall, it would have been between \$7
7 and \$10 million.

00050

1 Q. Do you recall whether anyone at Abbott
2 ever complained about the work product or the
3 services being provided by McKinsey in the course
4 of this arrangement?

5 MR. LORENZINI: Objection.

6 BY THE WITNESS:

7 A. Yes.

8 BY MS. TROAKE:

9 Q. And what do you recall?

10 A. What I recall is some concern about the
11 overall process complexity and the number of
12 teams; in some sense, the overall scope of the
13 effort being quite burdensome.

14 Q. Anything else?

15 A. No.

16 Q. Do you recall anyone from Abbott ever
17 complaining that McKinsey's work product or the
18 deliverables, as you described it, were inaccurate
19 or incomplete in any way?

20 MR. LORENZINI: Objection.

21 BY THE WITNESS:

22 A. No.

00074

12 (WHEREUPON, a certain document
13 was marked Hopfield Deposition
14 Exhibit No. 4 for
15 identification, as of 6/18/07.)

16 BY MS. TROAKE:

17 Q. Ms. Hopfield, I put in front of you
18 what has been marked as Exhibit 4.

19 Do you recognize this document?

20 A. Yes.

21 Q. And what is it?

22 A. It is the -- they are the first few
23 slides that were shown to kick off or start up the
24 day of the portfolio review.

00075

1 Q. Do you recall who prepared these

2 slides?

3 A. I did with my team.

4 Q. And were they shared with folks at
5 Abbott before the presentation?

6 MR. LORENZINI: Objection, lacks foundation.

7 BY THE WITNESS:

8 A. Yes.

00078

6 Q. If you could turn to, in Exhibit 4, the
7 page that -- you see there are Bates numbers, what
8 I call Bates numbers, the MCK numbers.

9 A. Yes.

10 Q. If you turn to the one ending 382,
11 please. It says, "Decision-making approach going
12 forward."

13 A. Yes.

14 Q. And under the "What" category, it says,
15 "Classify products into three groups," and then it
16 lists three areas, the last one being "Projects
17 which will not be retained."

18 A. Yes.

19 Q. Do you recall what that reference
20 means, "Projects which will not be retained"?

21 MR. LORENZINI: Objection to form.

22 BY THE WITNESS:

23 A. Yes. This was specifically about the
24 Knoll portfolio. When Abbott purchased Knoll, in

00079

1 addition to purchasing physical structure, they

2 purchased products, and the questions were which
3 of these projects should be retained in the new
4 legal entity and which should no longer be
5 continued.

6 BY MS. TROAKE:

7 Q. And category -- I'm sorry, does that --
8 are you describing this entire "What" to the
9 classified products into three groups, or are you
10 just saying the ones that would not be retained
11 were the Knoll ones -- ones in the Knoll
12 portfolio? I am confused.

13 A. Let me be more specific.

14 The driving force behind this off-site
15 was to see for the first time the Knoll portfolio
16 and assets. In order to do that fairly, we
17 actually discussed the integrated portfolio of
18 both companies, but the focus on our energy was on
19 Knoll.

20 We talked about whether we wanted to
21 retain those Knoll assets, and so that
22 classification of 1, 2 and 3, was really about do
23 we retain in the new entity the Knoll project or
24 asset, or in the point 3, which is not retained,

00080

1 do we decide to do something else with that asset.

2 Q. Do you recall whether there was any
3 discussion of any of the Abbott compounds in
4 relation to any of the items under "Classify
5 products into three groups"?

6 MR. LORENZINI: Objection, vague and
7 ambiguous.

8 BY THE WITNESS:

9 A. We discussed that while we were
10 reviewing Knoll, it was also an opportunity to
11 look at Abbott, but that the primary focus were on
12 the Knoll assets that were new to the R&D
13 leadership group.

14 BY MS. TROAKE:

15 Q. I understand that was the primary
16 focus.

17 A. Yes.

18 Q. I guess my question was, do you recall
19 any discussion around the Abbott compounds with
20 regard to these three categories?

21 MR. LORENZINI: Objection to the form.

22 BY THE WITNESS:

23 A. No. You mean in terms -- no.

24 BY MS. TROAKE:

00081

1 Q. Do you recall any discussions regarding
2 ABT-518 in relation to it being a project that
3 might not be retained at this off-site meeting in
4 March?

5 MR. LORENZINI: Objection to the form of the
6 question.

7 BY THE WITNESS:

8 A. I remember at the off-site, at the end
9 of the day, going through each compound of which

10 518 was one and having the leadership group
11 describe, based on the day, what they thought.

00081

20 Q. What about with respect to ABT-594, do
21 you have any recollection with respect to that
22 compound and any discussions in relation to it
23 being a project that might not be retained as
24 described in this slide?

00082

1 MR. LORENZINI: Objection to form.

2 BY THE WITNESS:

3 A. I recall that there was some concern
4 about the Phase II data, and, therefore, it
5 warranted further discussion.

00087

1 (WHEREUPON, a certain document
2 was marked Hopfield Deposition
3 Exhibit No. 5 for
4 identification, as of 6/18/07.)

5 BY MS. TROAKE:

6 Q. Ms. Hopfield, I put in front of you
7 what has been marked as Exhibit 5.

8 Would you take a look at that, please,
9 and let me know whether you recognize that
10 document.

11 A. Yes, I recognize it.

12 Q. And what is it?

13 MR. LORENZINI: Objection to the form.

14 BY THE WITNESS:

15 A. They are the overall summary of the
16 smaller group sessions that happened as part of
17 the off-site. And the discussion by the -- the
18 summary of the discussion that the group had by
19 product.

20 BY MS. TROAKE:

21 Q. And do you recall who is responsible
22 for putting together this summary, as you have
23 described it?

24 A. Yes. It was put together by Michael

00088

1 Williams.

2 Q. And so does that refresh your
3 recollection at all as to who else from McKinsey
4 was attending the March off-site?

5 A. Michael Williams would have been there
6 for at least part of it. I don't recall if he was
7 there for all of it. Between the two of us,
8 someone was there the whole time.

9 Q. So would the summary, which I take it
10 is the attached document, the document attached to
11 the e-mail, would that have been a collaboration
12 between you and Mr. Williams?

13 A. That's correct.

14 Q. And how did you do that? Did you take
15 notes in the course of the presentations over the
16 three days?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. This is not a summary of the
20 presentations. This is a summary of the sessions
21 that happen outside of these large plenary groups,
22 when the Abbott leadership as a smaller group was
23 meeting.

24 BY MS. TROAKE:

00089

1 Q. So the executive sessions we saw in the
2 prior document?

3 A. Correct. Right. And there, our
4 working norms would have been that Michael and I
5 would each take notes, and then we would have
6 compared notes and together have written this
7 document in the evenings.

00090

17 Q. And that list of next steps and
18 portfolio review, do you recall that is referring
19 to the attached document which is initialed
20 "portfolio prioritization"?

21 A. Yes, it is.

22 Q. And then in Mr. Williams' e-mail to
23 Dr. Leiden, the third sentence says, "You may wish
24 to make changes to the list before it is more

00091

1 broadly distributed and we can make edits based on
2 your handwritten comments if necessary."

3 Do you see that?

4 A. Yes.

5 Q. My first question about that sentence

6 is the reference to "before it is more broadly
7 distributed."

8 Do you recall whether this document,
9 initial portfolio prioritization, was more broadly
10 distributed than indicated in this e-mail?

11 MR. LORENZINI: Objection, calls for
12 speculation; lacks foundation.

13 MS. TROAKE: I am just asking if she knows.

14 MR. LORENZINI: I am just objecting.

15 BY THE WITNESS:

16 A. I don't know for this specific
17 document. I mean, I can infer. I mean, our
18 working norm was to have somebody closest to it
19 review it and then it would go out to the broader
20 R&D team.

00095

5 Q. If you look at the attachment, please,
6 the initial portfolio prioritization, it is
7 actually the one Bates-labeled 425, that page. It
8 has oncology as the first project group.

9 A. Yes.

10 Q. Do you see that?

11 There is a reference here to ABT-518.

12 Do you see that?

13 A. Yes.

14 Q. Under "Priority," it says, "Hold."

15 Do you have any recollection of what
16 that refers to, the word "hold"?

17 MR. LORENZINI: Objection.

18 BY THE WITNESS:

19 A. Yes. This was a case where we wanted
20 to understand the Phase II results and we could
21 not yet make a decision about what to do, and so
22 our assessment of it was put on hold until we knew
23 more.

24 BY MS. TROAKE:

00096

1 Q. The Phase II results -- I don't mean to
2 confuse you, but I know we were talking about a
3 Phase IIB study with respect to ABT-594
4 previously.

5 Is that what you were referencing?

6 A. Oh, I'm sorry. No, it would have been
7 another clinical result. I'm sorry. I was
8 getting ABT numbers confused.

9 Q. Okay.

10 A. There would have been other clinical
11 information, and I don't recall what we were
12 waiting for.

00098

20 Q. Under "Next steps," it also says next
21 to ABT-518, "Halt all further expenditure."

22 Do you see that?

23 A. Yes.

24 Q. Do you have any recollection of what

00099

1 that is referring to?

2 MR. LORENZINI: Objection.

3 BY THE WITNESS:

4 A. Yes. That was the idea that any
5 optional clinical or commercial spend should be
6 stopped until it was clear what was going to
7 happen to the compound.

8 BY MS. TROAKE:

9 Q. If you could turn two pages, the Bates
10 number is 427. At the top it says,
11 "Neuroscience," and just below that is "ABT-594."

12 Do you see that?

13 A. Yes.

14 Q. Under "Priority," that says, "P." And
15 you will note in the upper right-hand corner, P
16 indicates pending. Right?

17 A. Yes.

18 Q. Do you have any recollection of what
19 the difference between "pending" is as referenced
20 under 594 and the "hold" we saw next to 518?

21 A. Yes.

22 Q. And what is the difference?

23 A. "Pending" is when there were ongoing
24 trials and clinical spend and we simply did not

00100

1 know enough to make a decision. So the program
2 was to continue as planned by the team. And
3 pending we would make more decisions when we knew
4 more.

5 "Hold" meant do not spend any
6 incremental funds if not required until a decision

7 was made.

8 Q. Also, under "Next steps" for ABT-594,
9 there it says, "Await results from ongoing PII
10 trial."

11 Do you recall if that was reference to
12 the Phase IIB trial we were talking about?

13 A. Yes.

14 Q. Then it says, "Probable T." And if we
15 look in the upper right-hand corner, "T" means
16 terminate, correct?

17 A. Yes.

18 Q. Do you have any recollection about what
19 the reference to "probable T" meant?

20 MR. LORENZINI: Objection to the form of the
21 question.

22 BY THE WITNESS:

23 A. Yes. It was the collective judgment of
24 the smaller group discussing this that the

00101

1 likelihood was that the Phase II results would
2 indicate it should be terminated.

3 BY MS. TROAKE:

4 Q. And when you said the smaller group,
5 that's the executive session we were talking about
6 previously, and I think Dr. Leiden was present for
7 those?

8 A. Yes.

9 Q. And -- I'm sorry, you said the results
10 of the Phase IIB trial, those results would likely

11 cause them to terminate 594. Is that right; is
12 that what you said?

13 MR. LORENZINI: Objection.

14 MS. TROAKE: I am just trying to clarify her
15 prior answer.

16 MR. LORENZINI: I am just trying to object.

17 MS. TROAKE: I can see that.

18 BY THE WITNESS:

19 A. The group was guessing as clinicians
20 what they thought the likely outcome of the trial
21 would be and the likely outcome of the program.
22 And their guess was it would be negative, so they
23 would terminate.

24 BY MS. TROAKE:

00102

1 Q. Do you know what that guess, as you
2 have described it, was based on?

3 MR. LORENZINI: Objection, calls for
4 speculation.

5 BY THE WITNESS:

6 A. Decades of clinical development
7 experience and having seen more of the clinical
8 program.

9 BY MS. TROAKE:

10 Q. More of which clinical program?

11 A. Of the 594 preclinical Phase I,
12 et cetera. It's an Abbott compound, so they would
13 be aware of rather more of the data and therefore
14 they would have a viewpoint about the likelihood

15 of the trial being successful.

00103

4 MS. TROAKE: This will be Exhibit 6.

5 (WHEREUPON, a certain document
6 was marked Hopfield Deposition
7 Exhibit No. 6 for
8 identification, as of 6/18/07.)

9 BY MS. TROAKE:

10 Q. Ms. Hopfield, I put in front of you
11 what has been marked as Exhibit 6.

12 Do you recognize that document?

13 A. Yes.

14 Q. And what is it?

15 A. It is another version of the initial
16 portfolio prioritization.

17 Q. And do you know, or can you tell from
18 looking at Exhibit 6, whether it's a later version
19 of the initial portfolio prioritization from the
20 one that we saw attached in Exhibit 5?

21 A. I can't tell for sure.

22 Q. If you look at the second page of
23 Exhibit 6, there is a reference again under
24 "Oncology" to ABT-518.

00104

1 Do you see that?

2 A. Yes.

3 Q. Unlike the initial portfolio
4 prioritization we saw previously, under
5 "Priority," it now says, "hold/T."

6 And I think as in the past version, the
7 upper right-hand corner says T means terminate,
8 right?

9 A. Yes.

10 Q. Do you have any recollection with
11 respect to this version of the initial portfolio
12 prioritization as to what the "hold/T" under
13 "Priority" meant?

14 MR. LORENZINI: Objection.

15 BY THE WITNESS:

16 A. No, I don't recall how hold was turned
17 into a hold/T.

18 BY MS. TROAKE:

19 Q. Do you have any recollection of
20 discussions with anybody, either Michael Williams
21 or anyone at Abbott, as to why that was changed
22 from hold to hold/T?

23 A. No.

24 Q. With respect to the initial portfolio

00105

1 prioritization, the one we saw in Exhibit 5 and
2 this one, Exhibit 6, did McKinsey prepare this
3 document in part to assist Abbott in its decisions
4 about what to do with the portfolio?

5 MR. LORENZINI: Objection.

6 BY THE WITNESS:

7 A. We prepared it to document where the
8 group landed in the discussions and to give them
9 some documentation as they moved forward as a

10 team.

11 BY MS. TROAKE:

12 Q. But the purpose of giving them that
13 documentation, was it in part to assist them in
14 the process that they were going through?

15 A. Yes.

00107

1 (WHEREUPON, a certain document
2 was marked Hopfield Deposition
3 Exhibit No. 7 for
4 identification, as of 6/18/07.)

5 BY MS. TROAKE:

6 Q. Ms. Hopfield, we put in front of you
7 what has been marked Exhibit 7.

8 If you could take a moment to look at
9 that document, please, and let me know whether you
10 recognize it.

11 A. Yes.

12 Q. And what is it?

13 A. It is a progress review document to
14 update the integration leadership on where we were
15 with the R&D work stream.

16 Q. I'm sorry, you said it's a progress
17 review document; is that what you said?

18 A. Yes.

19 Q. And it was used to?

20 A. Update the integration leadership about
21 where we stood in terms of the R&D work stream.

22 Q. And it was created by McKinsey; is that

23 right?

24 A. Yes.

00108

1 Q. And it was created by McKinsey like the
2 initial portfolio prioritizations in the course of
3 your work for Abbott during this time period,
4 2001?

5 A. Yes.

6 Q. Was this provided to Abbott in some
7 form?

8 A. Yes. This would have typically been
9 handed out in paper copy at the meeting.

10 Q. And you said "at the meeting." Was
11 that a meeting on March 19, the date that is
12 indicated on the first page of Exhibit 7?

13 A. I think so.

14 Q. Do you recall who attended that
15 meeting?

16 A. No.

17 Q. Was Dr. Leiden at that meeting?

18 A. It would have been typical for him, but
19 I don't recall specifically who was at this
20 session.

21 Q. Do you recall whether it was the same
22 group who attended the executive sessions at the
23 earlier March portfolio review?

24 MR. LORENZINI: Objection.

00109

1 BY THE WITNESS:

2 A. I don't have any recollection of the
3 participants at this specific meeting. Typically
4 this would be some of those people, but not all.

00110

13 Q. And on this timeline, the last item
14 under the "Review" column says, "Final pharma R&D
15 program"; under "Date," it says, "May 8"; and
16 "Responsibility," "Pharma executive management
17 committee."

18 Do you see that?

19 A. Yes.

20 Q. Do you recall what that referred to?

21 A. Yes. That was a deadline for
22 presenting an integrated R&D program across the
23 two companies, with the overall portfolio and
24 budget.

00111

1 I need to amend an earlier answer.

2 Q. Okay.

3 A. The pharma executive management
4 committee, now that I look at this, is probably
5 not the R&D committee but, in fact, is the
6 business executive management committee. You had
7 asked me who was on that committee and so I gave
8 the wrong names of individuals.

9 Q. Okay. Which ones were wrong?

10 A. It would include Jeff Leiden. It would
11 not have Ed Ogunro and Eugene Sunn.

12 Q. Okay.

13 A. These would be business leaders.

14 Q. Coming back to the May 8 date, you said
15 that would be a deadline for presenting the final
16 R&D program with the overall portfolio and budget;
17 is that right?

18 A. Yes.

19 Q. And that would be the overall portfolio
20 for both Abbott and Knoll as one entity?

21 A. Yes.

00116

6 (WHEREUPON, certain documents
7 were marked Hopfield Deposition
8 Exhibit Nos. 8 through 11 for
9 identification, as of 6/18/07.)

10 THE VIDEOGRAPHER: Going back on the video
11 record at 3:30 p.m., the beginning of tape No. 3.
12 BY MS. TROAKE:

13 Q. Ms. Hopfield, I put in front of you
14 what has been marked as Exhibit 8.

15 Take a look at that, please, and let me
16 know whether you recognize that document.

17 A. Yes, I do recognize it.

18 Q. And what is it?

19 A. It's a fact pack, which Doane Chilcoat
20 produced, a member of my team, to help orient the
21 McKinsey team to the sort of practical details of
22 the R&D organization, so it was an internal
23 McKinsey reference document.

24 Q. So do you recall whether this

00117

1 particular document, Exhibit 8, was ever
2 circulated to anyone at Abbott?

3 A. I don't recall if it was shared with
4 anyone. As a matter of practice, though, we would
5 not broadly circulate a fact pack.

6 Q. And is a "fact pack" a term used at
7 McKinsey?

8 A. Yes, it is.

9 Q. And what does it mean?

10 A. It is a basic overview of fundamental
11 details that a team needs to accomplish an
12 engagement and it is just that: It is facts as
13 opposed to synthesis or ideas or detailed
14 analytics, it's just the basic details.

15 Q. And is one of the goals to be as
16 complete and accurate as possible in the fact pack
17 so people can complete the engagement, as you
18 described it?

19 MR. LORENZINI: Objection.

20 BY THE WITNESS:

21 A. The goal is to be fairly complete and
22 fairly accurate. It's not to necessarily have
23 this be complete. It's what we have pulled
24 together, and so it will vary in its detail and

00118

1 its accuracy. But it's the best we have.

00125

1 Q. Do you have any understanding, as you

2 sit here today, about the distinction between
3 nominal versus expected spending as it relates to
4 Abbott?

5 A. Yes.

6 Q. And what is your understanding?

7 MR. LORENZINI: Objection.

8 BY THE WITNESS:

9 A. My understanding is that the Abbott R&D
10 budgeting process has multiple puts and takes in
11 it. And there will be a pro forma budget that is
12 developed for the year, but then the spending has
13 its lumpiness, which is then tracked. And these
14 things are updated and there are several different
15 ways of describing those puts and takes to the
16 budget over time.

17 BY MS. TROAKE:

18 Q. And how, specifically, does that form
19 the distinction between nominal versus expected?
20 I don't see the link between what you just
21 described and nominal versus expected, which is
22 what my question related to.

23 A. I have heard those used as ways to
24 describe the difference between the actual run

00126

1 rate versus what they budgeted for the year.

2 Q. And what do you understand to be the
3 actual run rate, nominal or expected?

4 MR. LORENZINI: Objection, lacks foundation;
5 calls for speculation.

6 BY THE WITNESS:

7 A. Nominal.

8 BY MS. TROAKE:

9 Q. What is the basis for your
10 understanding?

11 A. Support that I provided to Abbott in
12 2002, 2003 on some R&D organizational issues.

13 Q. And what did that support relate to?

14 A. Specifically designing some
15 organizational structures to enable
16 decision-making of the combined R&D organization.

17 Q. Can you be more specific?

18 A. About a year after they had formed the
19 company, it was clear they did not have a way for
20 the top 15 or 20 R&D executives to work together
21 and make decisions, and they had not yet decided
22 how to divide up into subgroups. So I provided
23 support to John Leonard and some of his colleagues
24 to think about how the group should be organized.

00127

1 Q. And how did the issues of nominal
2 versus expected spending fit into that support?

3 MR. LORENZINI: I am just going to object to,
4 I think, this whole line of questioning on nominal
5 versus expected. There is some vagueness and
6 ambiguity in the questions, so I object to the
7 form.

8 BY THE WITNESS:

9 A. Although that work was entirely

10 organizational, as part of that, I would have seen
11 some budgets, some plans, and there were those
12 terms in those budgets and plans.

00133

24 Q. If you could turn to page 311 in

00134

1 Exhibit 8, please.

2 A. Yes.

3 Q. It's "Potential savings from
4 terminating development projects" at the top.

5 A. Yes.

6 Q. And over on the right, under the word
7 "Projects," it says, "Preliminary."

8 A. Yes.

9 Q. Do you recall what that refers to?

10 A. Yes. This was not a final client
11 recommendation. This was a thought exercise of if
12 we were to stop doing a number of projects, how
13 much money would that save to help us just
14 understand what some opportunities might be.

15 Q. And do you recall how you came up with
16 this list on this page?

17 A. Yes. We took all products that we
18 believed would be terminated from discussions with
19 the client, and products that either had some
20 challenging discussions or, you know, had some
21 reason to believe -- some reason to terminate it,
22 and it really was a thought exercise.

00149

18 Q. Do you recall whether McKinsey
19 ultimately made a recommendation to Abbott to
20 finally terminate ABT-594 and 518?

21 MR. LORENZINI: Objection.

22 BY THE WITNESS:

23 A. We made no recommendations on the
24 termination of any product.

00155

2 Q. I put in front of you what has been
3 marked Exhibit 11.

4 If you could take a moment to look at
5 that, please, and let me know whether you
6 recognize that document.

7 A. Yes, I do.

8 Q. And what is it?

9 A. It is an e-mail I sent to Jeff
10 following up on a number of action items from the
11 R&D strategy off-site.

12 Q. Now, the e-mails, both the top e-mail,
13 where you are sending it to Patricia Weber, which,
14 again, as the other e-mail we saw, says, "Please
15 print and put in mail folder." Right?

16 A. Yes.

17 Q. And your e-mail to Mr. Leiden and
18 others are both dated May 6, '01, right?

19 A. Yes.

20 Q. And your e-mail to him at the beginning
21 says, "Jeff, below are a few items from our Friday
22 afternoon session."

23 If you look back at exhibit -- the last
24 one we were looking at -- Exhibit 10, that

00156

1 discussion document is dated May 5, 2001.

2 A. Yes.

3 Q. Which is in and around the time you are
4 sending these e-mails.

5 Does that refresh your recollection at
6 all as to whether that discussion document was
7 used in a meeting with Abbott personnel?

8 MR. LORENZINI: Objection.

9 BY THE WITNESS:

10 A. I do not believe the more that I look
11 at that Exhibit 10 that that would have been used
12 with Abbott personnel. It does not have the style
13 and the kind of content that we would be sharing
14 with the client or a broader team.

15 I believe this was an internal document
16 that Doane Chilcoat developed to help us think
17 about things. There most likely was some document
18 on May 5th, but I do not believe it was that
19 document.

00161

5 Q. Okay. Do you know what the purpose or
6 do you recall what the purpose of this particular
7 document was?

8 MR. LORENZINI: Objection.

9 BY THE WITNESS:

10 A. Yes. They were the transcribed flip

11 chart notes of a discussion about next steps.

12 BY MS. TROAKE:

13 Q. And whose notes were they?

14 A. I don't recall who was at the flip
15 chart.

16 Q. Who was at the what?

17 A. At the flip chart.

18 Q. Okay. So do I have it right, someone
19 is writing on a flip chart?

20 A. Someone is writing, and this is my --
21 my team member transcribing that into an e-mail
22 form, into an electronic form.

23 Q. Do you recall whether the person at the
24 flip chart was an Abbott person or a McKinsey

00162

1 person?

2 A. No, I do not recall.

3 Q. Is it likely that it was a McKinsey
4 person?

5 A. Yes.

6 Q. And why would that be?

7 A. Because that was typically a role that
8 we played in the sessions, was to help facilitate
9 and organize.

10 Q. And the person at the flip chart, would
11 they be just the transcriber of what was being
12 discussed --

13 A. Yes.

14 Q. -- at the meeting?

15 On that document, "R&D strategy
16 retreat," the last item on the first page is
17 ABT-518, and it says, "terminate."

18 A. Yes.

19 Q. Do you recall why that reference was
20 put down on the flip chart, what the discussion
21 was around that?

22 MR. LORENZINI: Objection.

23 BY THE WITNESS:

24 A. No.

00166

2 Q. The last page in Exhibit 11 -- excuse
3 me, it's not the last page. It's the page
4 Bates-labeled 420.

5 A. Yes.

6 Q. Says, "2001 savings identified."

7 A. Yes.

8 Q. One of the items listed is ABT-518.

9 A. Yes.

10 Q. And says 2.5. I am assuming that's
11 2.5 million.

12 Do you recall whether it's millions?

13 A. It would be millions, yes.

14 Q. And do you recall why McKinsey was
15 providing that information to Abbott?

16 MR. LORENZINI: Objection.

17 BY THE WITNESS:

18 A. We weren't providing new information
19 for Abbott. We were simply providing for Jeff the

20 summary of the team conversations about savings,
21 so this was not a McKinsey perspective, this was
22 an output of the project team.

00215

4 BY MR. LORENZINI:

5 Q. And I believe you testified earlier
6 that the probable T on page 3 of Exhibit 5
7 represented a guess by people in that executive
8 group regarding the likelihood of ABT-594
9 continuing and that that was based on their sort
10 of general knowledge and results from studies
11 other than the ongoing Phase II trial?

12 A. Correct.

13 MS. TROAKE: Objection.

14 BY MR. LORENZINI:

15 Q. And you don't recall hearing anything
16 in that discussion about dropout rates in the
17 Phase II trial?

18 MS. TROAKE: Objection.

19 BY THE WITNESS:

20 A. No.

21 BY MR. LORENZINI:

22 Q. And so the probable T does not reflect
23 any assessment based on the Phase II trial since
24 that hadn't been completed yet, correct?

00216

1 MS. TROAKE: Objection.

2 BY THE WITNESS:

3 A. It was their cumulative judgment, which

4 could include some aspects of Phase II. Because
5 although the final results weren't in, they would
6 be aware of some parameters of the trial. So I
7 think it was the collective set of experiences
8 they had with the compound which could have
9 included aspects of the drug.

10 BY MR. LORENZINI:

11 Q. Aspects in terms of the protocol for
12 the trial, the dose ranging aspects of it, et
13 cetera?

14 MS. TROAKE: Objection.

15 BY THE WITNESS:

16 A. Yes. But also comments from
17 investigators, adverse event reports that had gone
18 to the agency and therefore were known.

19 BY MR. LORENZINI:

20 Q. But you don't know -- do you recall
21 anything --

22 A. I don't recall any specific comments.
23 I am simply indicating that that probable T was
24 the full weight of the clinical experiences they

00217

1 had, which would include some sense of what was
2 happening in Phase II.

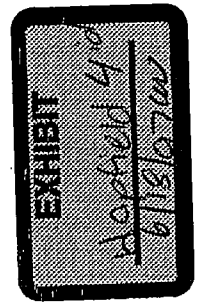
HOPFIELD Dep. Ex. 4 / PLs' FC

CH-228011-049-MADRAS/jbrd

BUILDING A WORLD OF OPPORTUNITIES TOGETHER



Development portfolio review kick-off
March 7, 2001



CONFIDENTIAL

MCK 00377

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STRUCTURE OF PRESENTATION

PAGE NOT TO BE INCLUDED IN PRESENTATION

Slides

- Introduction (page 2)
- Who "we" are (page 3)
- Objectives (page 4)
- Decision-making approach (page 5)



J. Leiden

- Ground rules (page 6)
- Agenda (pages 7-9)



J. Leonard

CH-228011-049-MADRAS/jbRD

INTRODUCTION

- Our goal is to be the world's premier health care company
- Together we must build a leading, global R&D portfolio by leveraging our
 - Outstanding scientists
 - Exciting technologies
 - Scale
 - Global reach
- This unified portfolio review process is the first step in achieving our goal
 - Success will require tough choices

CH-228011-049-MADRAS/jlbRD

WHO "WE" ARE - COMBINED STRENGTH

People

- Total employees 70,700
- Number of scientists 5,400

Pipeline

- Preclinical >30
- In development 46
 - Phase 1 16
 - Phase 2 17
 - Phase 3 13
- Filed 5

Capabilities

- Total facilities 156
- Manufacturing sites 67
 - worldwide
- Global pharmaceutical R&D investment ~\$950 million

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OBJECTIVES FOR THIS WEEK'S REVIEW MEETING

- To gain a shared understanding of all development projects across the new company
- To identify the critical issues, timelines, and upcoming decisions for each project, emphasizing
 - Clinical
 - Commercial merits
- To provide senior management with the technical inputs necessary to make portfolio decisions over the coming weeks

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DECISION-MAKING APPROACH GOING FORWARD

What

- Classify products into three groups
 1. Projects to definitely retain
 2. Projects warranting further discussion/assessment
 3. Projects which will not be retained

When

- Initial list of projects in the third group will be communicated within 1-2 weeks
- All other projects to continue as planned until final prioritization completed by early May

How

- Single uniform process across the combined portfolio
- Consistent set of criteria to evaluate all project opportunities

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MEETING GROUND RULES

Presenters

- Provide fact-based, objective perspective on the project
 - Focus on most important issues (given time constraint)
 - Identify critical milestones and funding requirements
 - Propose the product plan and give your rationale
- Stay for presentations within own individual therapeutic area/venture groups

Audience

- Ask questions of clarification during the time allocated for discussion
- Respect time constraints
- Maintain strict confidentiality of the material presented

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AGENDA – WEDNESDAY, MARCH 7

		Presentation	Discussion	Presenter
7:30 a.m.	Welcome/Introduction	10 minutes		J. Leiden
7:40 a.m.	Meeting objectives	10 minutes		J. Leonard
Anti-infectives				
7:50 a.m.	ABT-492	20 minutes	5 minutes	C. Craft
8:15 a.m.	HSR-903	30 minutes	10 minutes	T. Hirose/R. Krauthmeier
Anti-virals				
8:55 a.m.	Triangle projects • HIV and HBV (FTC; DAPD)	30 minutes	10 minutes	M. Health-Chiozzi
9:35 a.m.	<i>Morning Break</i>			
9:55 a.m.	Urology BSF 42027 (ETA/BPH)	30 minutes	10 minutes	M. Luz/U. Legler
10:35 a.m.	Asthma Hokunalin tape	15 minutes	5 minutes	T. Hirose/R. Krauthmeier
10:55 a.m.	Oncology ABT-510	20 minutes	15 minutes	P. Nisen
11:30 a.m.	ABT-751	20 minutes	15 minutes	P. Nisen
12:05 p.m.	<i>Lunch</i>			
1:05 p.m.	ABT-518	15 minutes	5 minutes	P. Nisen
1:25 p.m.	Rubitecan	20 minutes	5 minutes	P. Nisen
1:50 p.m.	Theragyn	20 minutes	5 minutes	P. Nisen
2:15 p.m.	ABT-627	30 minutes	10 minutes	P. Nisen
2:50 p.m.	<i>Afternoon break</i>			
3:15 p.m.	Cardiology Darusentan (LU 135252) and other ETAs	30 minutes	10 minutes	M. Luz/U. Legler
3:55 p.m.	Thrombosis PEG-hirudin	30 minutes	10 minutes	V. Ifthekar/U. Legler
4:35 p.m.	Ancord	30 minutes	10 minutes	N. Bender
5:15 p.m.	Urokinase/Pro-urokinase	30 minutes	10 minutes	S. Guptha

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AGENDA - THURSDAY, MARCH 8

	Presentation	Discussion	Presenter
7:30 a.m.	Neuroscience		
8:10 a.m.	ABT 594	10 minutes	B. McCarthy
8:40 a.m.	ABT-963	15 minutes	Granneman/Doan/Bell
	BSF 201640	10 minutes	B. Rendenbach-Mueller/B. Hargan
9:20 a.m.	BSF 74398 (Parkinson)	10 minutes	
10:00 a.m.	<i>Morning Break</i>		
10:20 a.m.	Dilaudid OROS	15 minutes	B. Gold/R. Krauthmeimer
11:20 a.m.	BSF 190555 (Schizophrenia)	10 minutes	B. Rendenbach-Mueller/B. Hargan
12:00 p.m.	<i>Lunch</i>		
1:00 p.m.	Hydrocodone	10 minutes	Abbott (TBD)
1:20 p.m.	Bimoclomol (ABT-822)	10 minutes	B. Wallin
2:00 p.m.	Gastro-enterology	5 minutes	S. Dawe/R. Krauthmeimer
2:20 p.m.	Ganaton (pro-kinetic)	10 minutes	T. Hirose/ R. Krauthmeimer
3:00 p.m.	TU-199 (proton pump inh.) AU-224 (colon pro-kinetic)	5 minutes	T. Hirose/ R. Krauthmeimer
3:25 p.m.	<i>Afternoon break</i>		
3:45 p.m.	Phase III Projects	15 minutes	C MacLeod
4:30 p.m.	Levosimendan	15 minutes	A. Pethö-Schramm/U. Legler
5:15 p.m.	Rythmol SR D2E7	30 minutes	C. Spiegler/E. v. Borcke

CH-228011-049-MADRAS/jbrd

AGENDA -- FRIDAY, MARCH 9

	Phase III (Continued)	Presentation	Discussion	Presenter
7:30 a.m.	Segard	45 minutes	15 minutes	L. Daum/E. v. Borcke
8:30 a.m.	J695	30 minutes	10 minutes	R. Janocha/E. v. Borcke
9:10 a.m.	Clivarine	30 minutes	15 minutes	F. Misselwitz/U. Legler
9:55 a.m.	<i>Morning break</i>			
10:15 a.m.	ABT-773	30 minutes	15 minutes	C. Craft
11:00 a.m.	Phase IV Projects			
11:20 a.m.	Clarithromycin	15 minutes	5 minutes	C. Olson
11:40 a.m.	Omnicef	15 minutes	5 minutes	C. Olson
12:00 p.m.	Kaletra	15 minutes	5 minutes	E. Sun
	Norvir	15 minutes	5 minutes	E. Sun
12:20 p.m.	<i>Lunch</i>			
1:20 p.m.	Meridia (Sibutramine)	15 minutes	5 minutes	E. Chong/W. Hargan
1:40 p.m.	Upima	15 minutes	5 minutes	S. Bukofzer
2:00 p.m.	Trandolapril (patch, intervention trials)	15 minutes	5 minutes	B. Rendbach-Mueller/ U. Legler/N. Bender
2:20 p.m.	Fenofibrate	15 minutes	5 minutes	D. Yannicelli
2:40 p.m.	Depakote	15 minutes	5 minutes	K. Sommerville
3:00 p.m.	Gengraf	15 minutes	5 minutes	T. Japour
3:20 p.m.	Conclusion			J. Leiden


HOPFIELD Dep. Ex. 5 / PLs' FH

Jessica Hopfield
03/13/2001 07:22 PM

To: Patricia Weber/NJE/NorthAmerica/MCKINSEY@MCKINSEY
cc:
Subject: Please print and put in mail folder

----- Forwarded by Jessica Hopfield/NJE/NorthAmerica/MCKINSEY on 03/13/2001 07:23 PM -----

Michael Williams
03/13/2001 04:10 PM

To: Jeff Leiden <jeff.leiden@Abbott.com>
cc: Jessica Hopfield/NJE/NorthAmerica/MCKINSEY@MCKINSEY, Dick
Ashley/CHI/NorthAmerica/MCKINSEY@MCKINSEY, David
Keeling/CHI/NorthAmerica/MCKINSEY@MCKINSEY
Subject: List of next steps from portfolio review 

Jeff,

Please find attached a detailed list of the next steps by project, coming out of last week's development review. Where possible, we have assigned the responsibilities and timings we picked up during the discussions. You may wish to make changes to the list before it is more broadly distributed and we can make edits based on your handwritten comments if necessary.

We are also in the process of compiling the comments and results from the evaluation forms which we'll forward to you by later this week.



NEXT STEPS - development portfolio prioritization



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INITIAL PORTFOLIO PRIORITIZATION

Project	Priority	Next steps	Responsibility	Timing	C- continue P- pending T- terminate
Anti-infectives					
ABT-492	C	<ul style="list-style-type: none"> • Address safety issues (including QTc) with internal/ expert review • Determine how many indications at launch (pay back) 	• J. Leonard	-	
HSR-903	T	<ul style="list-style-type: none"> • Consider trading with Daiichi • Halt any new expenditure 	• J. Tyree	-	
ABT-773	C	<ul style="list-style-type: none"> • Assess side effects issues with expert review (QTc and liver tox.) • Ensure all drug interactions are adequately covered • Assess relative to Ketek 	• J. Leonard • J. Leonard • I. Loew	-	
Urology					
BSF 420627	P	<ul style="list-style-type: none"> • Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> - Reasons for failure of the SKB ETa/b antagonist - Design short (~4 week) PoP trial for symptom relief - Rationale for sustained release formulation - Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May	
Hypothyroidism					
T3/T4	P	<ul style="list-style-type: none"> • Assess most appropriate ratio • Gain FDA feedback on study design • Determine ex-US market attractiveness (price) 	• J. Leonard	• By May	
Asthma					
Hokunalin tape	P	<ul style="list-style-type: none"> • Conduct market research on acceptance by different patient segments • Determine how to position against long acting beta agonists and combination inhalers • Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino • J. Tyree	• May	

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing	C- continue P- pending T- terminate
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned 	
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned 	
ABT-518	Hold	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> CMC group Senior management 	<ul style="list-style-type: none"> May 	
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May 	
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May 	
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP 	
			<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> By May 	

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis				
Darusentan (LU 135252)	Hold	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) If proceed, plan for pilot to look at effects in sperm and tetragonectomy Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> Project team J. Tyree 	<ul style="list-style-type: none"> ongoing ASAP
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> B. Dempsey Project team 	<ul style="list-style-type: none"> Ongoing

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience				
ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • J. Tyree • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	• E. Fiorentino	• By June
	T	<ul style="list-style-type: none"> • Terminate outside Japan 	• Bob Funck	• By May
	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team • E. Fiorentino 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review – 2 day meeting with J. Lennard's group (already in process) – ½ day session with senior management group • Important actions include – Approach FDA for fast track and compassionate use – Develop strategy for DMARD claim in first submission – Assess need for Enbrel assay to detect HAHAs – Assess delivery device options – Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program – Profile Celltech product – Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various • J. Tyree 	<ul style="list-style-type: none"> • By May • By May

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• Talk to partners	• J. Tyree	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	• Conduct commercial assessment for CNS and depression (P&L)	• B. Dempsey, J. Arnott, E. Florentino	• ASAP
		• Assess combination therapy with fibrates	• Project team	
		• Assess outcomes trial design to meet preferred commercial profile; determine payback		
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

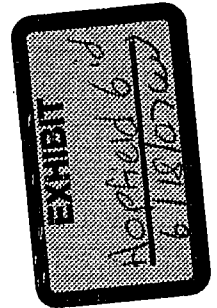
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INITIAL PORTFOLIO PRIORITIZATION

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-Infectives ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/ expert review Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> Consider trading with Daiichi Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	<ul style="list-style-type: none"> • J. Leonard • J. Leonard • I. Loew-Friedrich 	-
Urology BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma Hokunalin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	<ul style="list-style-type: none"> • A. Higgins/ E. Fiorentino • J. Tyree 	• May



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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team CMC group Senior management 	<ul style="list-style-type: none"> As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> Senior management 	<ul style="list-style-type: none"> May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard J. Tyree 	<ul style="list-style-type: none"> By May
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial <ul style="list-style-type: none"> If move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Leonard, P. Nisen J. Tyree 	<ul style="list-style-type: none"> ASAP By May

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> ASAP
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> ongoing
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (Is diabetes an option?) 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> ASAP
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Cilvarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial -- probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTC • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew-Freidrich • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew-Freidrich 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

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C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By June
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	<ul style="list-style-type: none"> • Bob Funck 	<ul style="list-style-type: none"> • By May
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Martene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Leonard's group (already in process) - ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various 	<ul style="list-style-type: none"> • By May • By May
			<ul style="list-style-type: none"> • J. Tyree 	

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US -- consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

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C- Continue
P- Pending
T- Terminate

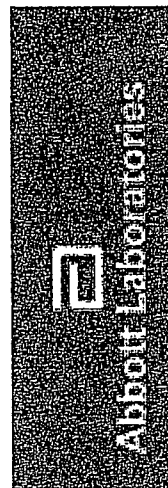
INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Amott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

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R&D Integration Update



Discussion document

March 19, 2001

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CH-228011-076jsm/cgDC

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AGENDA

- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- Update on the financial baseline
- Preliminary synergy opportunities

CH-228011-076(sm/cgDC

TIMELINE TO FINALIZE THE PHARMA R&D PROGRAM

Review	Date	Responsibility
Global development review	March 7-9	John Leonard
Budget baseline finalized	April 2	Bob Funck
Global discovery reviews	April 22-24	Dan Norbeck
Portfolio analysis Abbott and Knoll compounds	April 20	Keith Hendricks
Global pharma R&D strategy retreat	May 4-6	TBD*
Final pharma R&D program	May 8	Pharma Executive Management Committee

* Head of discovery, venture head, and commercial representative for each therapeutic area to present individual strategies

INITIAL PORTFOLIO PRIORITIZATION

CH-228011-076ism/cgDC

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives				
ABT-492	C	<ul style="list-style-type: none"> • Address safety issues (including QTc) with internal/expert review • Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> • Consider trading with Daiichi • Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> • Assess side effects issues with expert review (QTc and liver tox.) • Ensure all drug interactions are adequately covered • Assess relative to Ketek 	• J. Leonard • J. Leonard • I. Loew	-
Urology				
BSF 420627	P	<ul style="list-style-type: none"> • Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> - Reasons for failure of the SKB ETa/b antagonist - Design short (~4 week) PoP trial for symptom relief - Rationale for sustained release formulation - Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism				
T3/T4	P	<ul style="list-style-type: none"> • Assess most appropriate ratio • Gain FDA feedback on study design • Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma				
Hokunalin tape	P	<ul style="list-style-type: none"> • Conduct market research on acceptance by different patient segments • Determine how to position against long acting beta agonists and combination inhalers • Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino	• May
			• J. Tyree	3

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

CH-228011-076[sm]/cgDC
 C- Continue
 P- Pending
 T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> • Pursue proof of concept • Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	• Project team	• As planned
ABT-751	C	<ul style="list-style-type: none"> • Pursue proof of concept • Use echocardiogram to monitor potential cardiotoxicity • Resolve potent drug manufacturing approach 	• Project team	• As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> • Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate • Halt all further expenditure 	• CMC group • Senior management	• May
Rubitecan	P	<ul style="list-style-type: none"> • Significant clinical rework required (funded by partner)- further in-depth review required • Make a proceed decision when 2Q data available 	• J. Leonard	• By May
Theragyn	P	<ul style="list-style-type: none"> • Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> - Determine if there is a PoC to support claim - Address GMP issues - Determine best control to demonstrate efficacy • Re-look at partnership contract 	• J. Leonard	• By May
ABT-627	C	<ul style="list-style-type: none"> • Seek alternative funding (e.g., NCI) before starting major trial • If move ahead <ul style="list-style-type: none"> - Determine how to ensure NDA filing in 2004 - Get FDA input since survival not primary endpoint - Harmonize US and EU study design and inputs • Consider partnership (e.g., BI or established oncology player) 	• J. Tyree • J. Leonard, P. Nisen	• By May • ASAP
			• J. Tyree	• By May

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C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree Project team J. Tyree 	<ul style="list-style-type: none"> ASAP ongoing
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro B. Dempsey 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing

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C- Continue
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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

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C- Continue
P- Pending
T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	• E. Fiorentino	• By June
			• Bob Funck	• By May
	T	• Terminate outside Japan	• Project team	• Immediate
TU-199			• Project team	• ASAP
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	• E. Fiorentino	
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Lennard's group (already in process) - 1/2 day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHAS - Assess delivery device options - Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	• J. Leonard	• By May
			• Various	• By May
			• J. Tyree	7

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T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

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C- Continue
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T- Terminate

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arnott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	<ul style="list-style-type: none"> • Ensure no redundant trials with TAP in Europe 	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

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AGENDA

- Update on the development portfolio review
- **Overview of the phase 2 R&D integration plan**
- Update on the financial baseline
- Preliminary synergy opportunities



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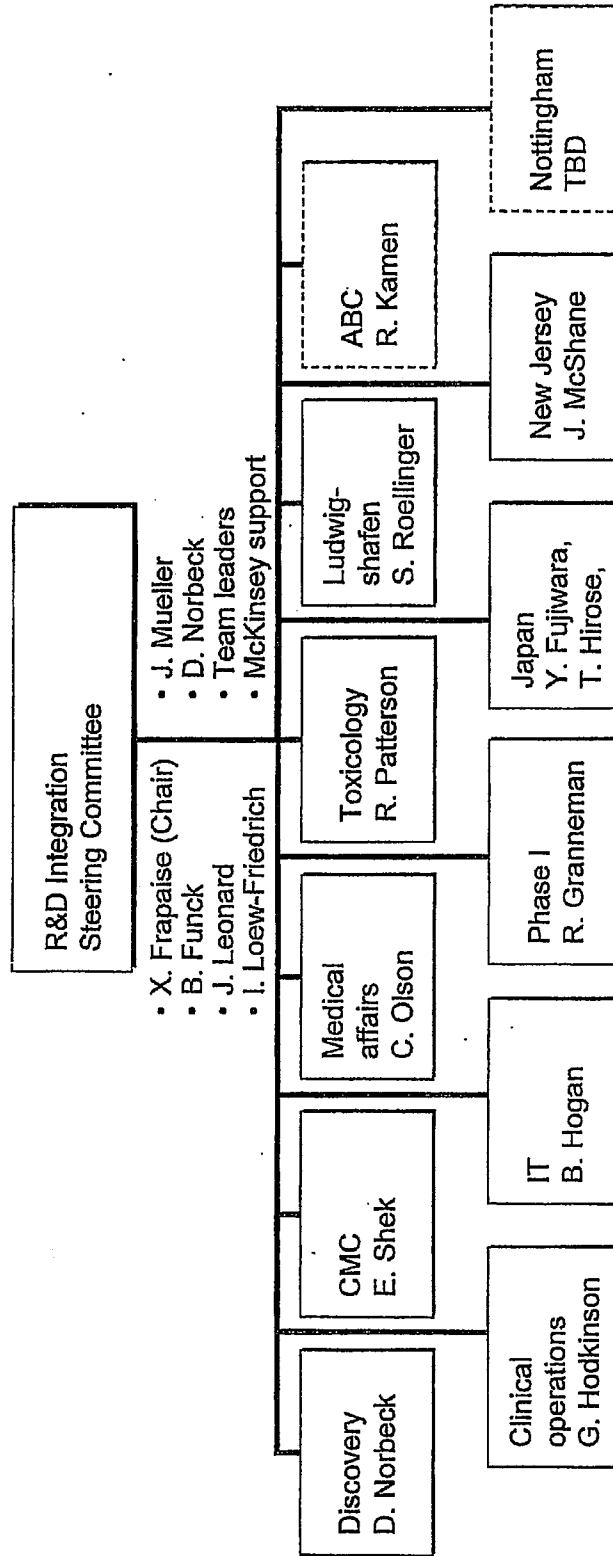
OVERALL OBJECTIVES

- Our goal is to be the world's premier health care company with a leading, global R&D organization
- To reach that goal, we must take advantage of this unique opportunity to develop an effective long-term strategy and organizational structure
- At the same time, we must balance our long-term objectives against the short-term financial targets that we must meet

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REVISED PHASE 2 INTEGRATION TEAMS



Responsibilities of each team
<ul style="list-style-type: none"> • Develop a strategic approach • Develop synergy plan (e.g., select appropriate sites, identify opportunities to improve performance and productivity) • Allocate resources across projects • Suggest a new organization for the combined company • Evaluate and select appropriate people for the organization

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OVERALL SUB-TEAM WORK PLAN

Activity	Timing
1. Launch sub-teams with clear mandates and consistent approach	March 16
2. Develop fact base (x-Knoll, x-Abbott organization structure, activities, headcount, budgets) and initial functional area strategies	March 23
3. Identify initial list of synergy opportunities to improve productivity and performance (structure, processes, purchasing, etc.)	March 28
4. Initial evaluation and prioritization of opportunities	April 2
5. Finalize recommendations and implementation plans for senior R&D management <ul style="list-style-type: none">- Synergy plan- Organization structure and process improvements- People selection	April 30
6. Allocate resources across projects after final prioritization is completed	Post-May 8

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DEVELOP THE FACT BASE AND STRATEGY

Mission
Why the unit exists

Activities
How the unit provides end products

End products
What the unit provides to achieve its missions

Strategic objectives
Limited number of key objectives for the unit

List mission, activities, end products and strategic objectives for the group and subgroup

Budget

_____	_____
_____	_____
_____	_____
Total \$	_____

Draw up organization charts and baseline budgets for the group and subgroups

End products

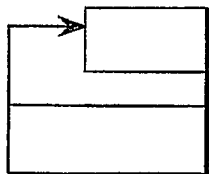
_____	\$
_____	\$
_____	\$
_____	\$

Allocate costs to each product or service (e.g., project-specific costs)

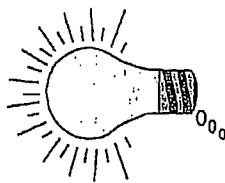
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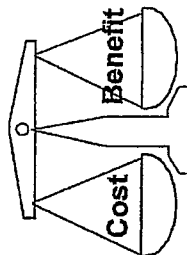
GENERATE AND EVALUATE IDEAS



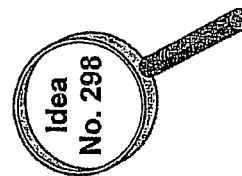
Set "stretch target" to generate ideas (e.g., 15-25%)



Brainstorm ideas to reduce costs and improve service to users



Refine and evaluate each idea to determine cost and benefit

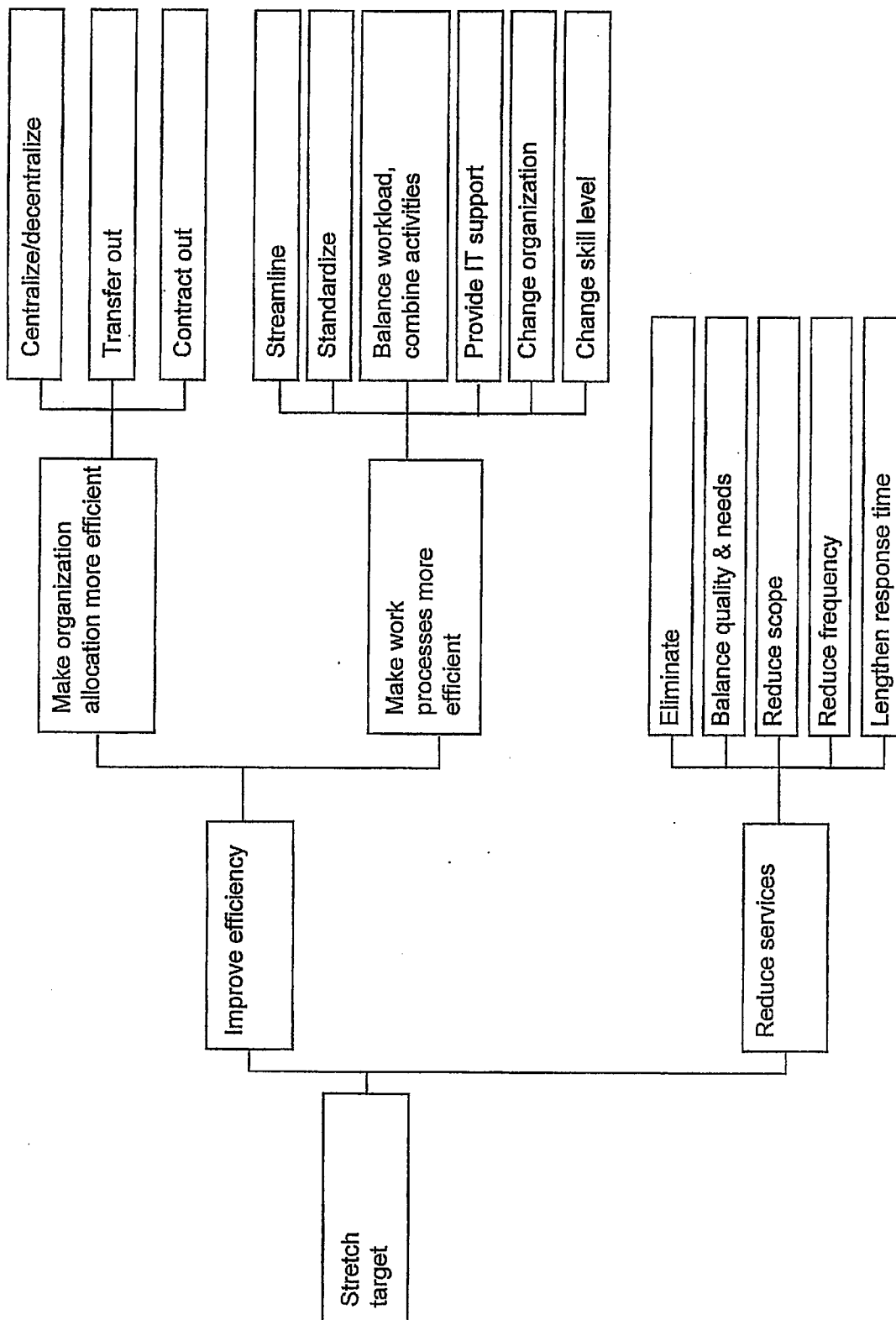


Review each idea with key managers, users, suppliers, and the R&D Steering Committee

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IDEA GENERATION FRAMEWORK

ILLUSTRATIVE



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STATUS OF PHASE 2 INTEGRATION TEAMS

☒ Complete
☐ Partially complete
☐ Not started

Team	1. Launch subteam	2. Develop fact base and strategy	3. Identify synergy opportunities	4. Evaluate/ prioritize opportunities	5. Develop implementation plans
Discovery	n/a	<input type="radio"/> Review in preparation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinical operations	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CMC	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IT	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical affairs	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Phase I	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Toxicology	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Japan	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ludwigshafen	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
New Jersey	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ABC	<input type="radio"/>	n/a	n/a	n/a	<input type="radio"/>

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TEAM MANDATE – CLINICAL OPERATIONS & PROJECT MANAGEMENT**Objective**

- To identify high value, short term (2 yr) and long-term process, resourcing and structural opportunities to realize synergies and increase efficiency and effectiveness in the drug development and clinical operations processes. Improvements will focus on Quality, Cost and Speed

Key issues

- Diversity in the way Clinical & Drug Development programs are run: 4 different operating models; at least 60 clinical teams (not including PIV affiliate run programs; and 58 Drug Development teams across the company
- Customer (investigator) satisfaction with Abbott is low (CenterWatch Survey, US and Europe)
- Clinical outsourcing is the norm – 96% of Abbott studies outsourced in 2000 (\$?). Conducted on as needs basis per activity rather than functional or program level (i.e. not strategic)
- Diversity in practices, processes, procedures, documents and systems
- Multiple support groups with differing operating models, processes and requirements
- Lack of ways to share skills, knowledge, information and expertise

End products*Short and long term strategy:*

- Identify preferred operating models for Clinical Operations and Project Management
- Strategic resource plan for clinical operations
- Define opportunities to improve operational efficiency and effectiveness
- Identify which services to consolidate and centralize
- Propose systems for consistent collection, reporting and sharing of project information

Integration plan:

- New project management structure
- New clinical operations structure
- Work plan for achieving synergies

Team members

- Gilliam Hodkinson – Chair
- Tom Woidat – Finance analyst
- Ellis Purcell – clin ops sub-team
- Kathe Balinski – clin ops sub-team
- Mathias Luz – clin ops sub-team
- Jerry Osbourne – project management sub-team
- Leticia Delgado-Herrera – project management sub-team
- Eddie Chong – project management sub-team
- Rick Granneman – DM/Stats sub-team
- Jennifer Manski – project management sub-team
- Doane Chilcoat – McKinsey

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CMC TEAM MANDATE

Objective <ul style="list-style-type: none"> • Develop CMC processes leading to a strategic approach • Develop synergy plan (e.g., select appropriate sites, identify opportunities to improve performance and productivity) • Suggest a new organization for the combined company • Evaluate and select appropriate people for the organization 	
End products	Key issues <ul style="list-style-type: none"> • Scope of CMC R&D responsibilities • Contract out vs. internal activities • Location (proximity to R&D, Manufacturing Facilities (how many, where) • Pilot plants (how many, size, location) • Organization (functional, size) • Performance and productivity improvements • Potent drug strategy • Drug delivery capabilities

Team members

- Efraim Shek – Chair
- Steve Szostak, Karen Session – Finance analyst

- Kathy McFarland, Fritz Richter, Jim Mitchell, John McShane
- Doane Chicoat – McKinsey

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TEAM MANDATE – TOXICOLOGY AND RELATED SCIENCESEXAMPLE**Objective**

- Develop an integration plan that reduces costs, improves efficiencies and eliminates redundancies
- Develop a strategy to implement the plan over time using all resources optimally

Key issues

1. Degree of centralization of scientific capabilities and strategies to achieve goals
2. Balance of demands with capacities
3. Elimination of unnecessary activities
4. Strategic balance of internal and external resourcing

End products

1. Reduced duplication of facilities, personnel, capital investment over time
2. Reduce any underabsorption with CRO work and overabsorption with dispersion of tasks to underutilized areas
3. Reduction of activities not essential to the development process, to redirect toward more vital activities or eliminate
4. Devise a strategy to increase CRO use in areas where cost effective and reduce in areas where premium paid

Team members

- Reid Patterson – Chair
- Tom Woidat – Finance analyst
- 6 DSE Directors
- Fritz Richter, Global Head Pharm Ctrs
- Ray Dorsey – McKinsey

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TEAM MANDATE – PHASE IEXAMPLE

Objective <ul style="list-style-type: none">• Determine appropriate scope and level of services to be provided• Design optimal structure and staff for Phase 1 (Clinical Pharmacology) group• Identify opportunities for improvement within the group	Key issues <ul style="list-style-type: none">• Extent of global responsibilities for Clin Pharm group• Integration of Statistics and Clin Pharm activities into drug development now and in the future• Services to be provided internally vs. externally• Appropriate number of Phase I units	End products <ul style="list-style-type: none">• Optimal organizational structure and staff for the group• Assessment of value of a European Clin Pharm service to venture heads• List of services and activities to be provided by the group• Set of group opportunities for improvement including financial impact and implications• Assessment and recommendation of viability of Phase I units based on several factors (e.g., capabilities, cost-effectiveness, capacity, future investments requested)
Team members <ul style="list-style-type: none">• Rick Granneman – Chair• Kay Rekau – Finance analyst	<ul style="list-style-type: none">• Walid Awni, Bob O'Dea, Laura Williams, Carl Mendel (MO), Mike Rubison• Ray Dorsey – McKinsey	

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AGENDA

- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- **Update on the financial baseline**
- Preliminary synergy opportunities

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Knoll Integration Finance Action Items

Progress on the R&D Baseline

- Obtained 2001/2002 Knoll Plan by Program by Location.
- Sent out detailed finance data request for all Knoll sites to validate 2001 Plan, provide functional expense detail, plus adjust for March 2 close date. Information expected back 03/23.
- Assigned finance support to each R&D integration sub-team to manage financial baseline data and value synergy opportunities.

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Knoll Integration Finance Action Items

Next Steps to Finalize Baseline by April 2

- Update Abbott 2001 Plan Budgets via April Update Reviews.
- Line up x-Knoll and Abbott budgets by functional area.
- Consolidate into a single base line budget for 2001 (will change post May 8th with new portfolio priorities and sub-team generated synergies).
- Complete assessment of differences between the x-Knoll budget and the acquisition model (including budget shifts due to definitional changes).
- Finalize Hancock funding impact.
- Finalize Meridia outcome study cost/accounting treatment.
- Prepare cost estimate for New Jersey satellite office.

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**Knoll Integration
Finance Action Items**

Items Not Considered in Baseline Spend

- International Affiliate Medical/Regulatory Affairs.
- International Phase IIIb/IV expense.
- International local R&D spend.
- HPD R&D (other than Abbott R&D reorg).

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AGENDA

- Update on the development portfolio review
- Overview of the phase 2 R&D integration plan
- Update on the financial baseline
- **Preliminary synergy opportunities**

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PRELIMINARY SYNERGY OPPORTUNITIESPRELIMINARY

Clinical operations	Opportunity	Estimated cost savings
Clinical operations	<ul style="list-style-type: none"> Use strategic outsourcing best practices across clinical programs (e.g., use 1 vendor for 1 drug program to realize efficiency savings) <ul style="list-style-type: none"> Recently changed budgeted plans for ABT-627 PIII program, placing 2 studies with a single CRO 	<ul style="list-style-type: none"> Significant incremental volume discount (e.g., 10-15%) <ul style="list-style-type: none"> ABT-627 example will realize \$6.2mill in savings over 4 years
	<ul style="list-style-type: none"> Use of Abbott Preferred providers for all Knoll Phase II-IV clinical service outsourcing 	<ul style="list-style-type: none"> Up to 10% on Knoll preferred provider spend
Phase I	<ul style="list-style-type: none"> Assess and rationalize Phase I units and CRO spend. Currently, two Phase I units are in operation (one in Ludwigshafen and one in Waukegan) and extensive outsourcing also conducted. 	<ul style="list-style-type: none"> TBD

Source: Sub-teams

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PRELIMINARY SYNERGY OPPORTUNITIES (CONTINUED)PRELIMINARY

Opportunity	Estimated cost savings
<div data-bbox="733 1457 816 1646" data-label="Text">Information technology</div> <ul style="list-style-type: none"> • Disentangle R&D IT support from BASF corporate support • Currently BASF is charging \$4 million/month for IT services to all of the former BASF Pharma. Significant overhead embedded within this arrangement 	<ul style="list-style-type: none"> • ~\$1-2 million in 2001 • \$2-4 million(annual) thereafter* (for R&D)
<ul style="list-style-type: none"> • Identify and stop work on redundant R&D IT projects • Main contributor is the overlap of BASF Pharma Emerging Dossier project with Abbott e-submissions program 	<ul style="list-style-type: none"> • \$1-2 million in 2001 • \$1-2 million in 2002
<ul style="list-style-type: none"> • Enforce BASF indemnification for R&D software licenses. • Abbott entitled to this under the Amendment to the Purchase Agreement. 	<ul style="list-style-type: none"> • ~\$3-4 million in cost avoidance for 2001 only

* Additional investment may be required to achieve the savings. These savings may have been "counted" by the IT integration team
Source: IT sub-team

HOPFIELD Dep. Ex. 8 / PLs' FL

CH-228011-079jlr/dc

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Overview of Abbott R&D



Fact Pack
April 2001

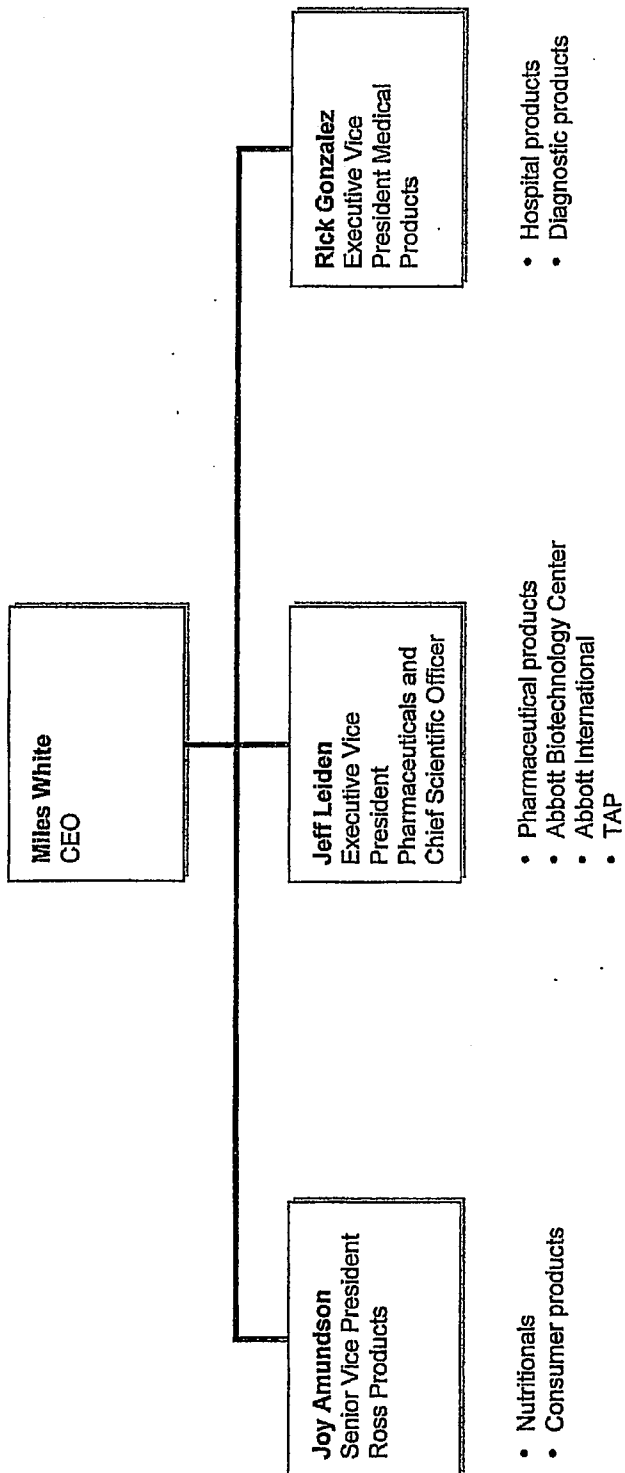
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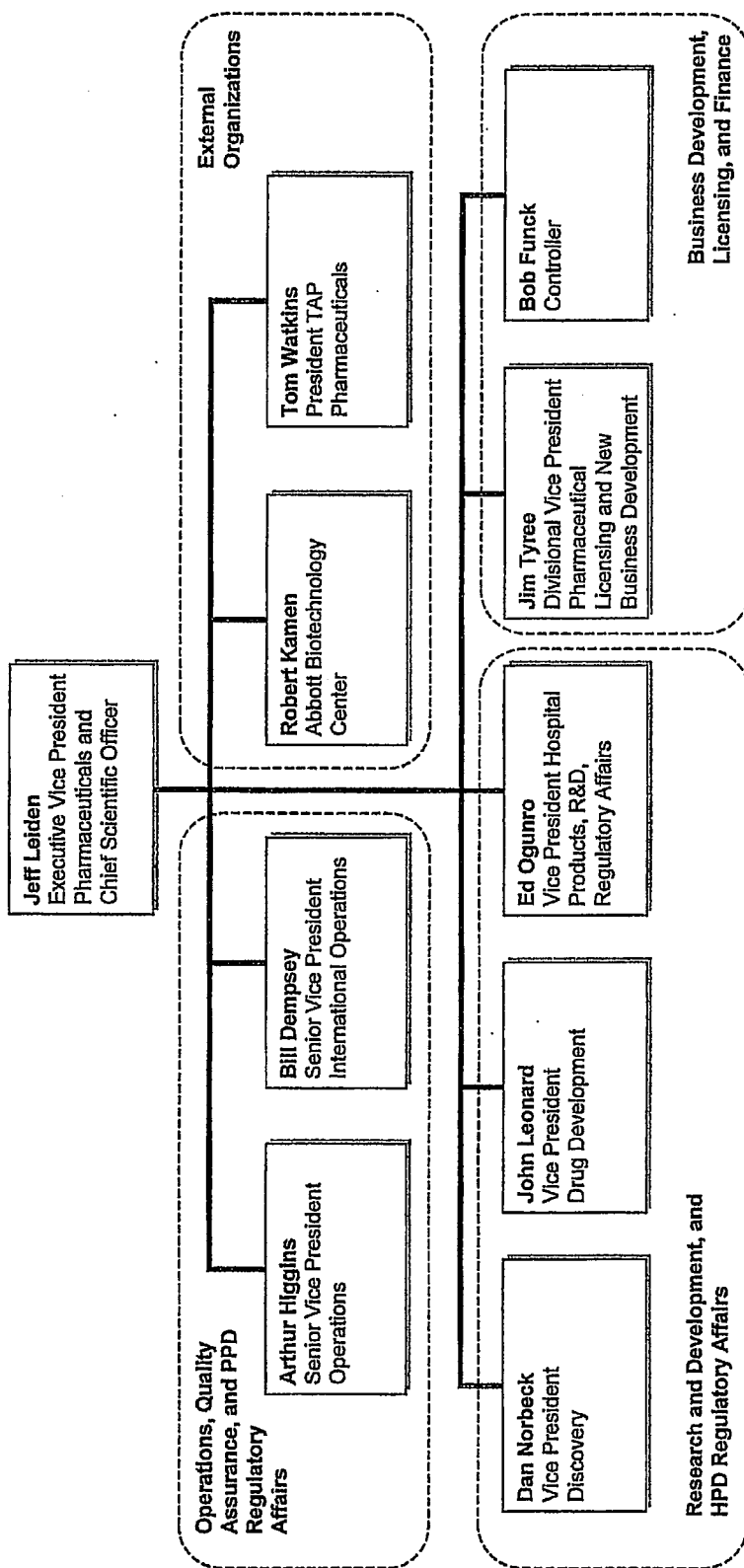
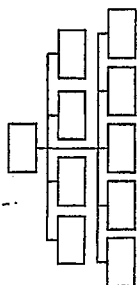
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ABBOTT LABORATORIES ORGANIZATION

1

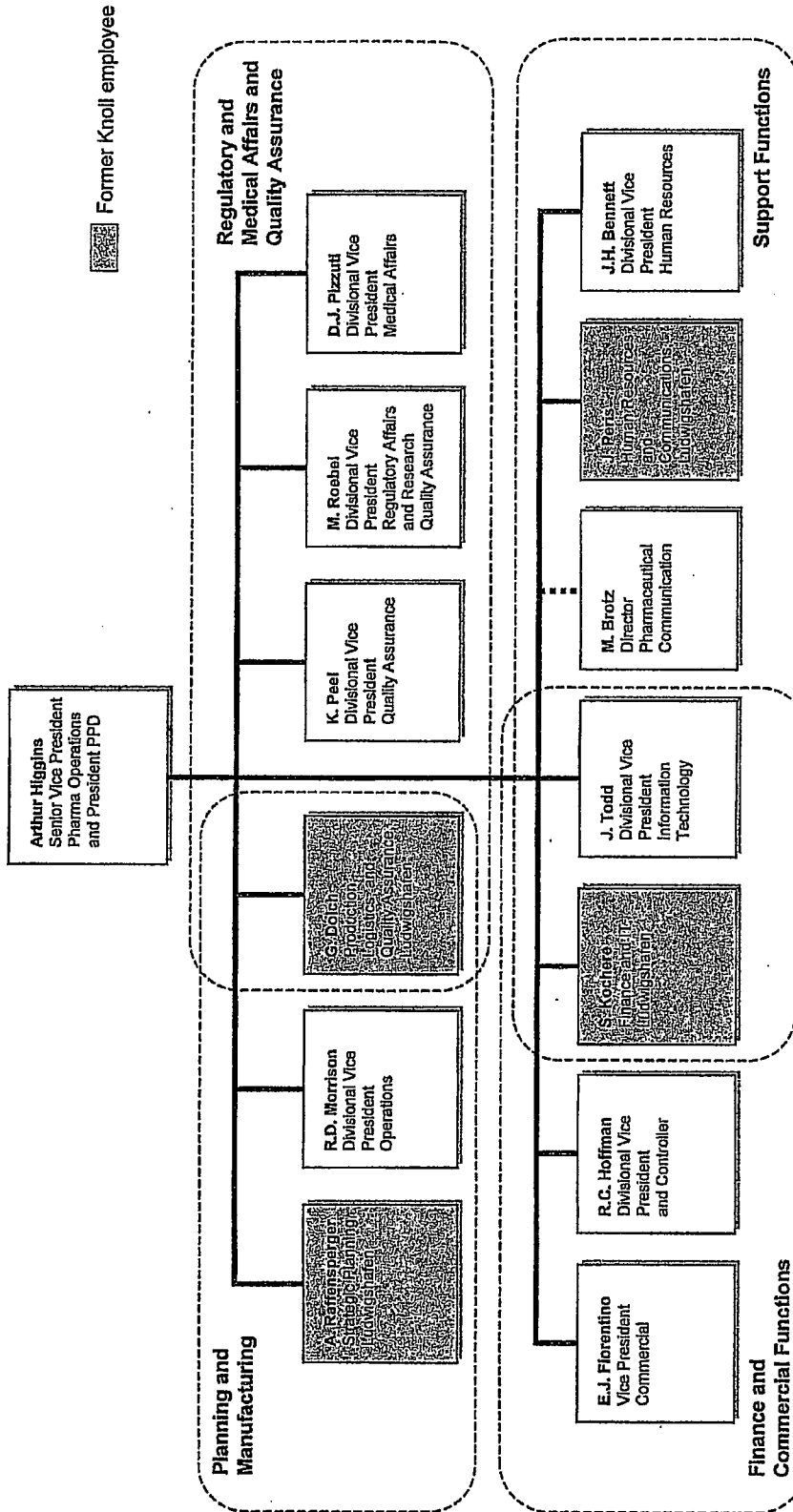
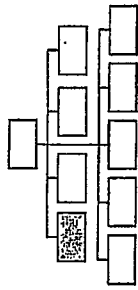
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GLOBAL PHARMACEUTICAL ORGANIZATION



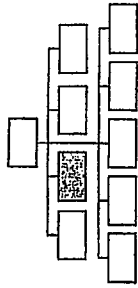
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PHARMACEUTICAL OPERATIONS ORGANIZATION

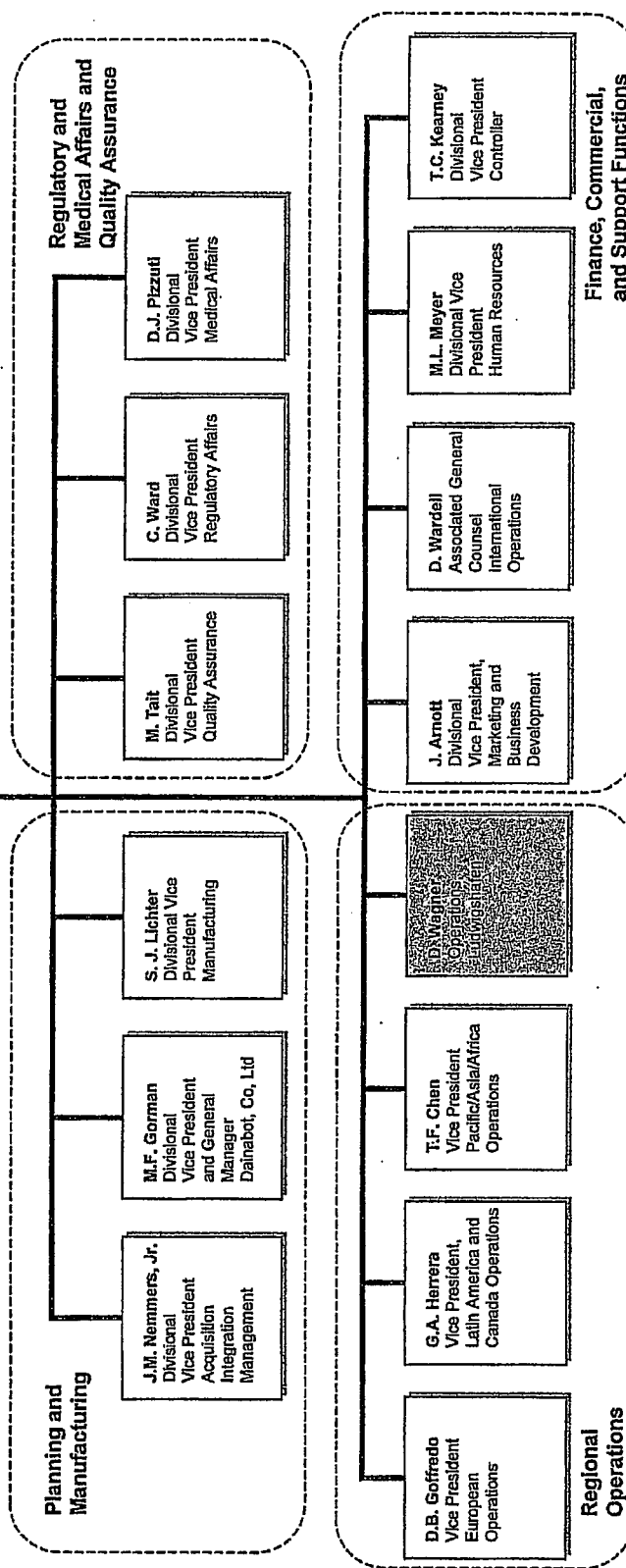


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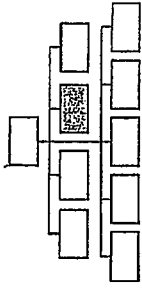
INTERNATIONAL PHARMACEUTICAL OPERATIONS ORGANIZATION



Former Knoll employee

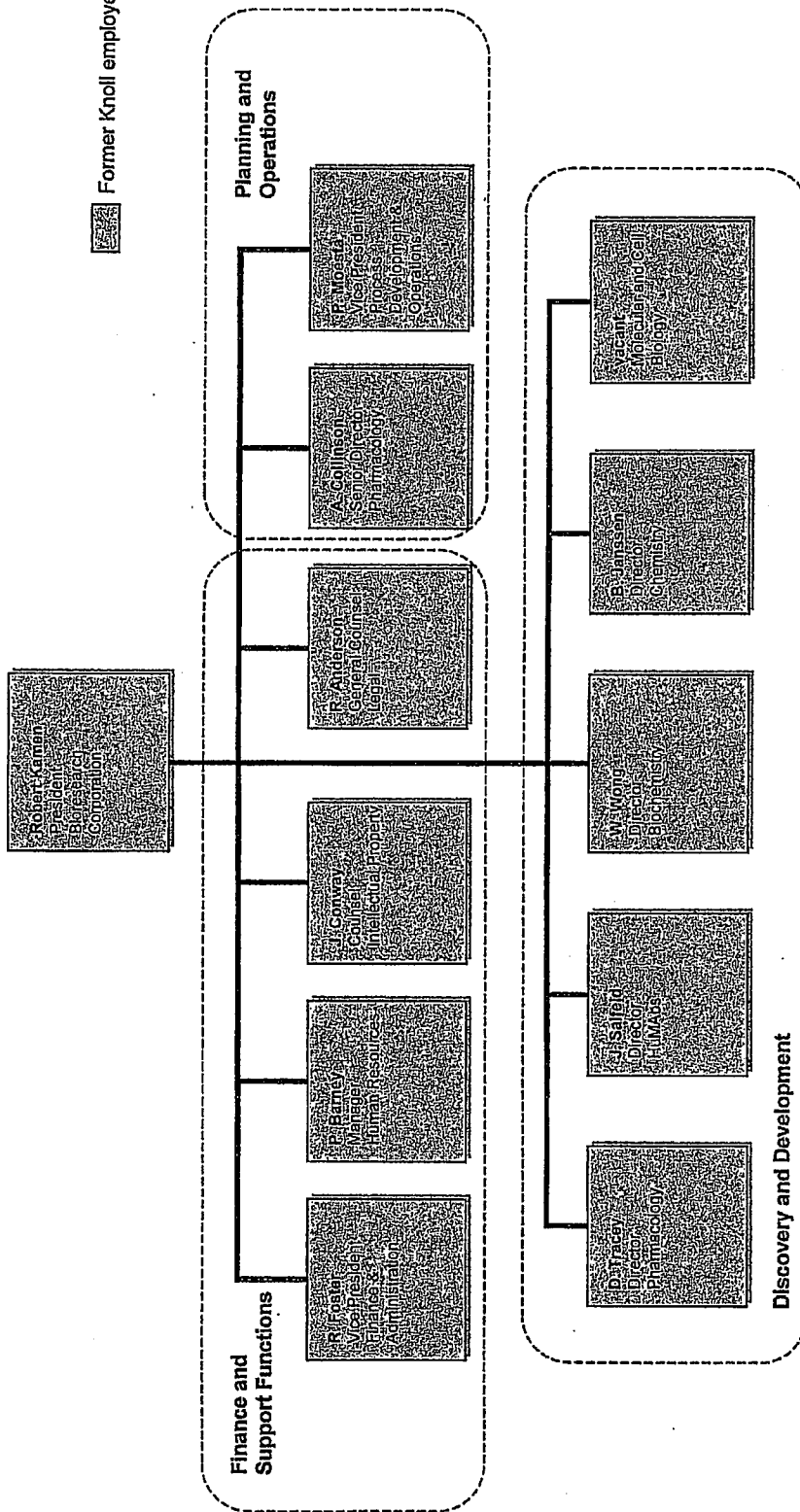


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Former Knoll employee

ABBOTT BIOTECHNOLOGY CENTER ORGANIZATION

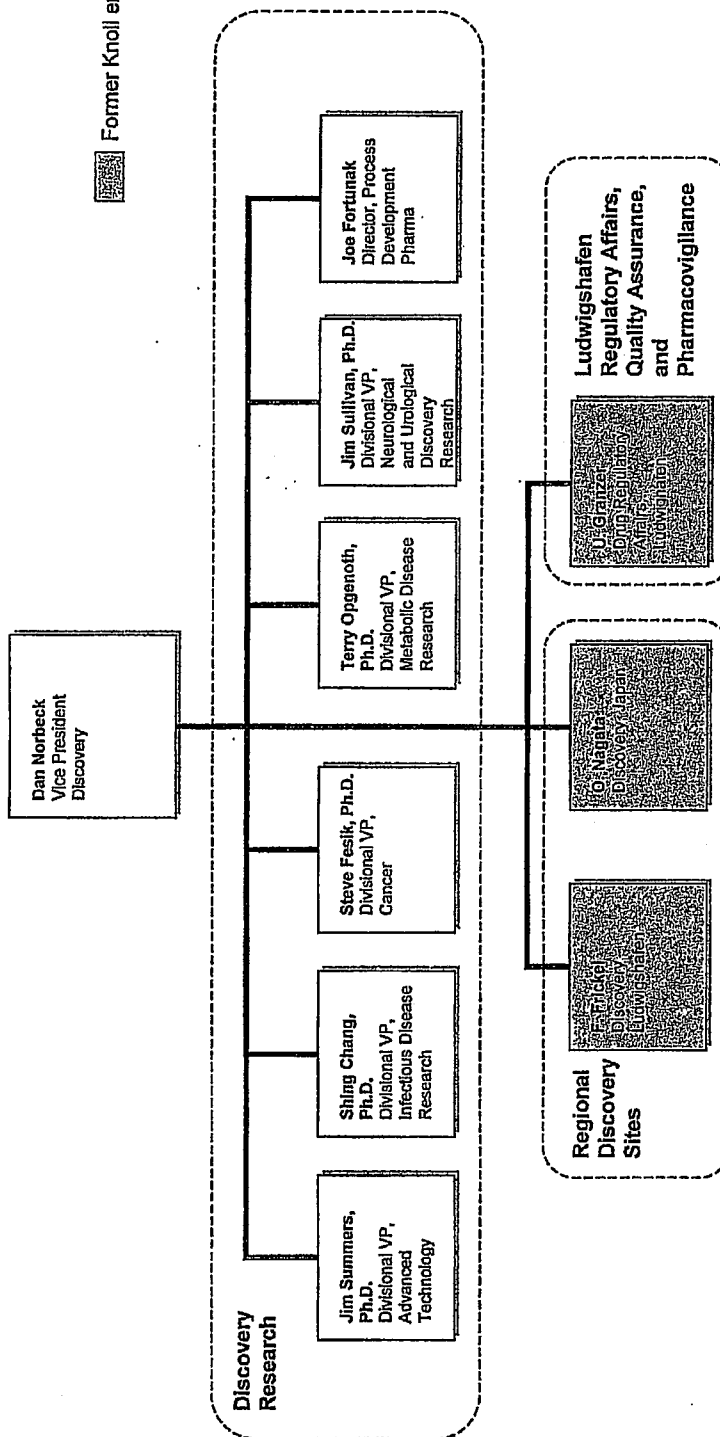


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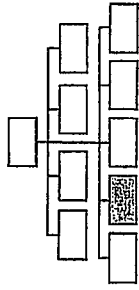
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 Former Knoll employee



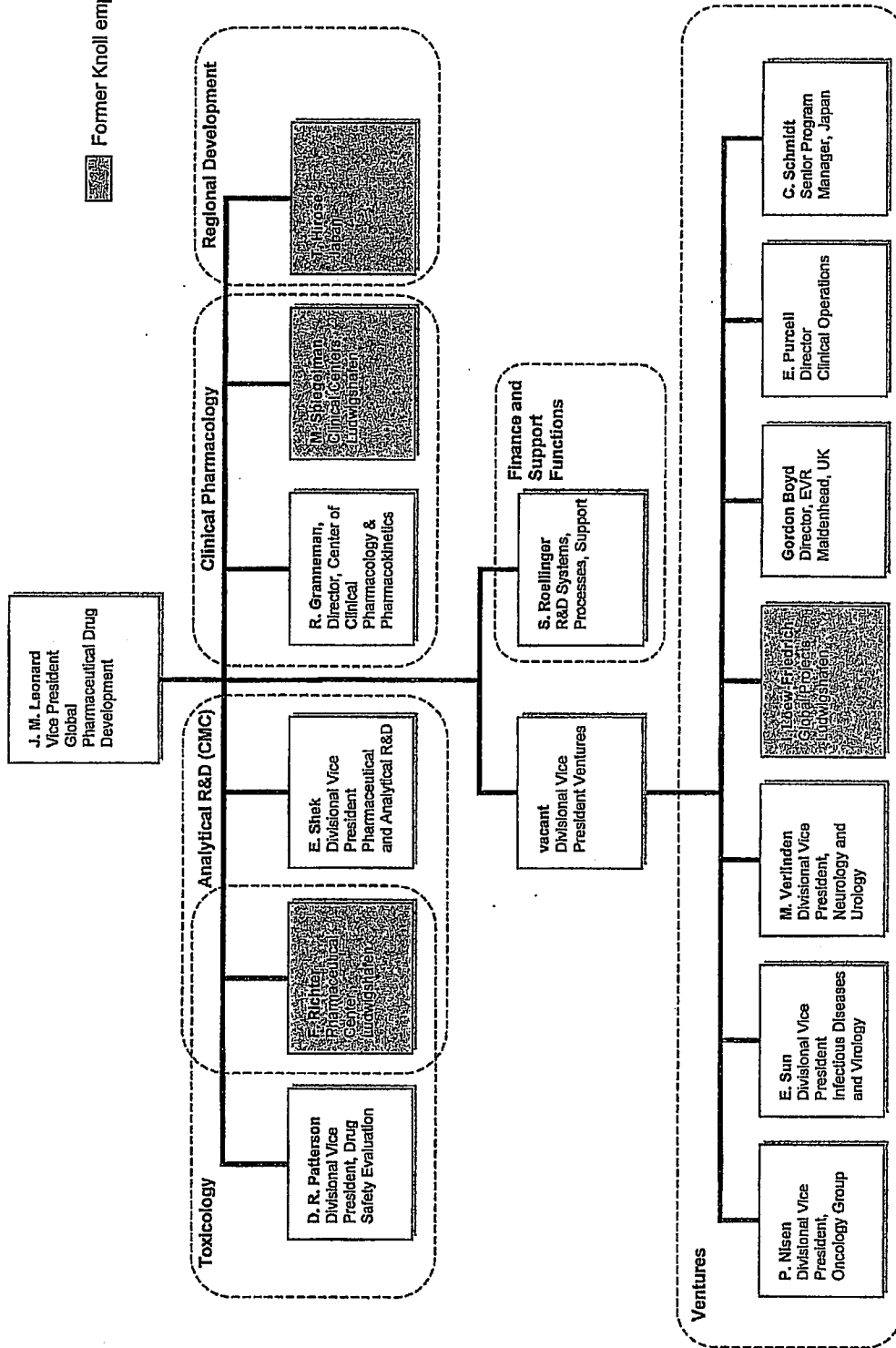
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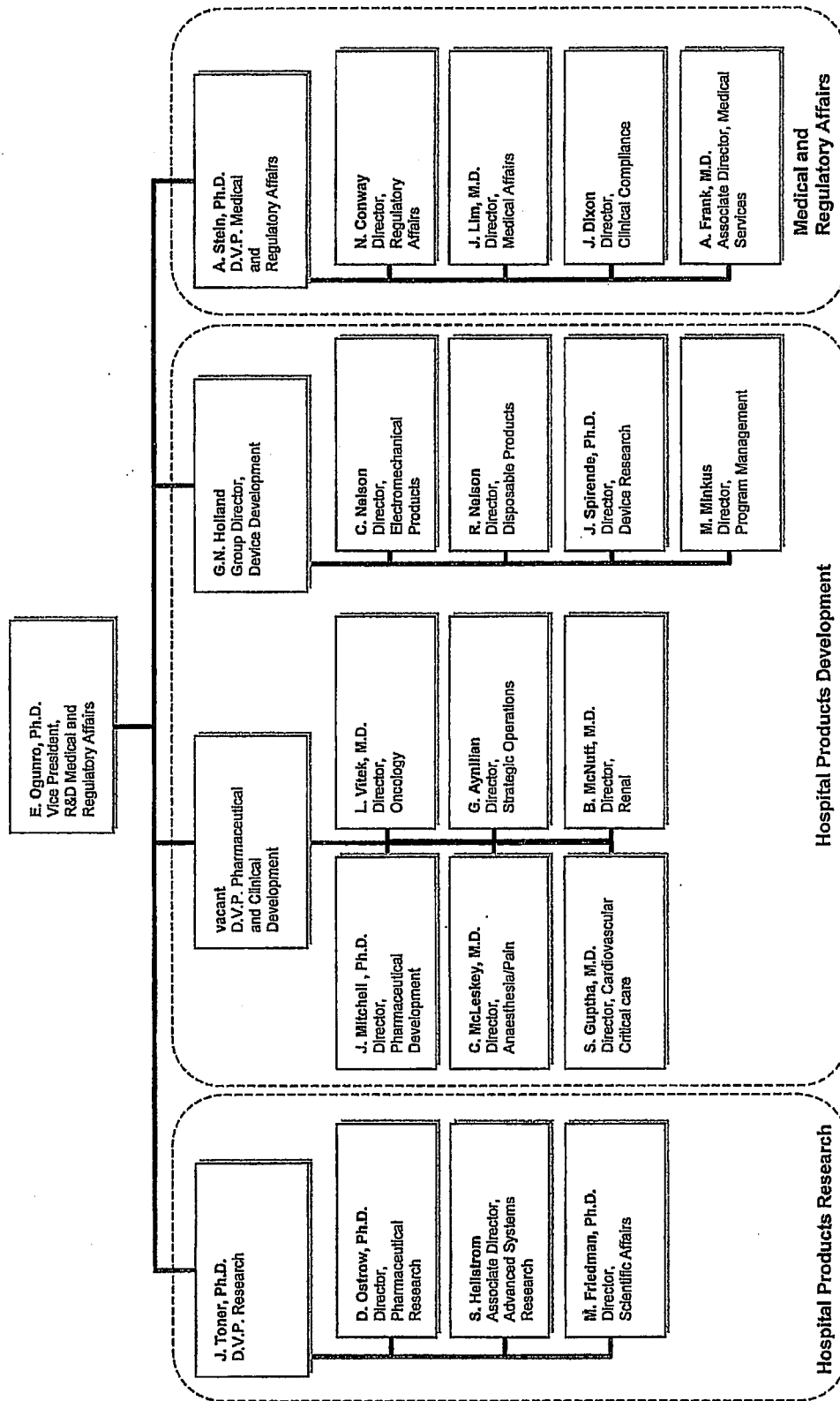
Former Knoll employee

GLOBAL PHARMACEUTICAL DRUG DEVELOPMENT ORGANIZATION

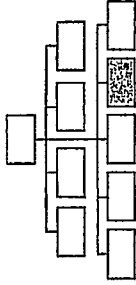


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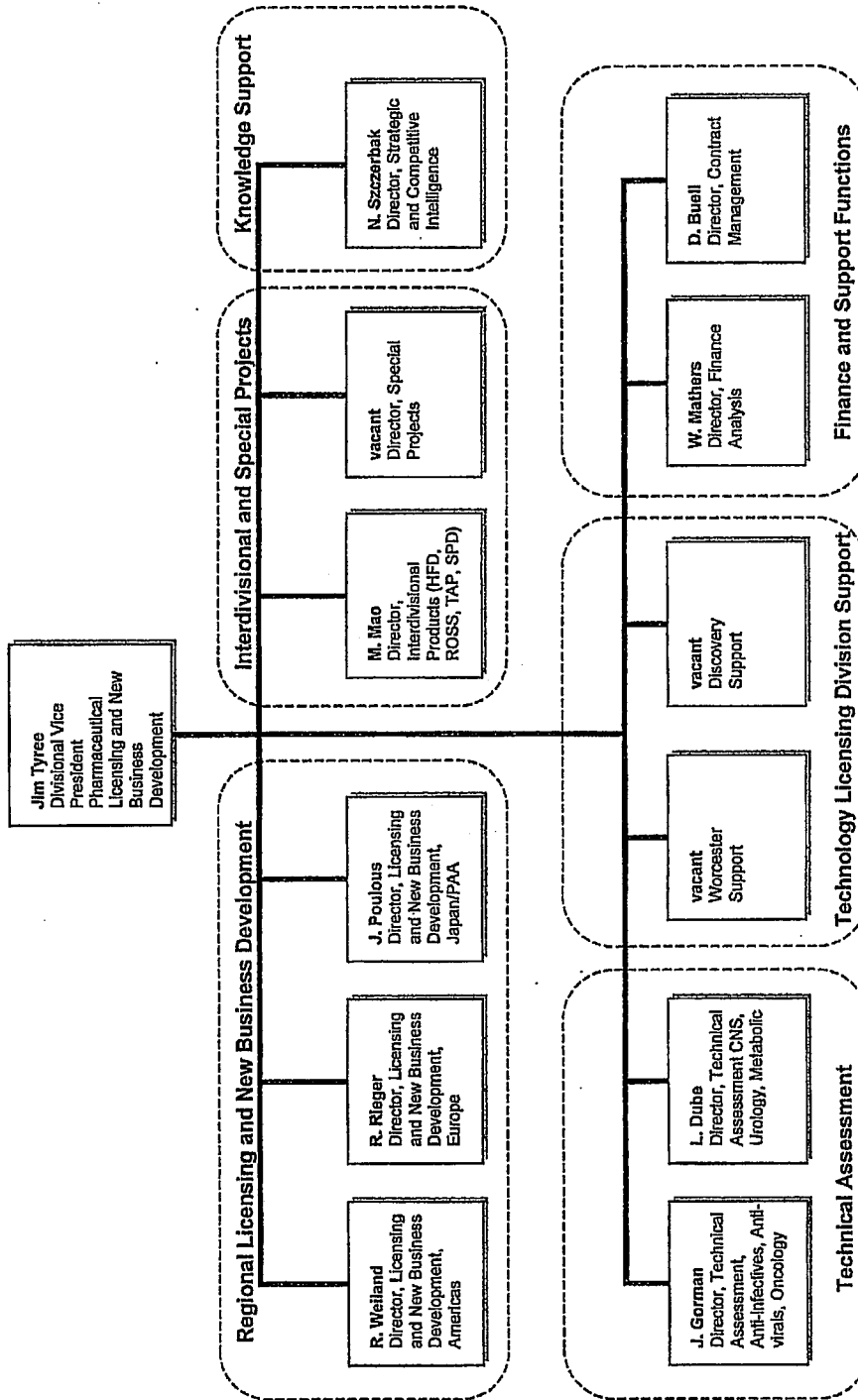
HOSPITAL PRODUCTS DIVISION R&D AND MEDICAL AND REGULATORY AFFAIRS ORGANIZATION



CH-228011-079jb/rcDC

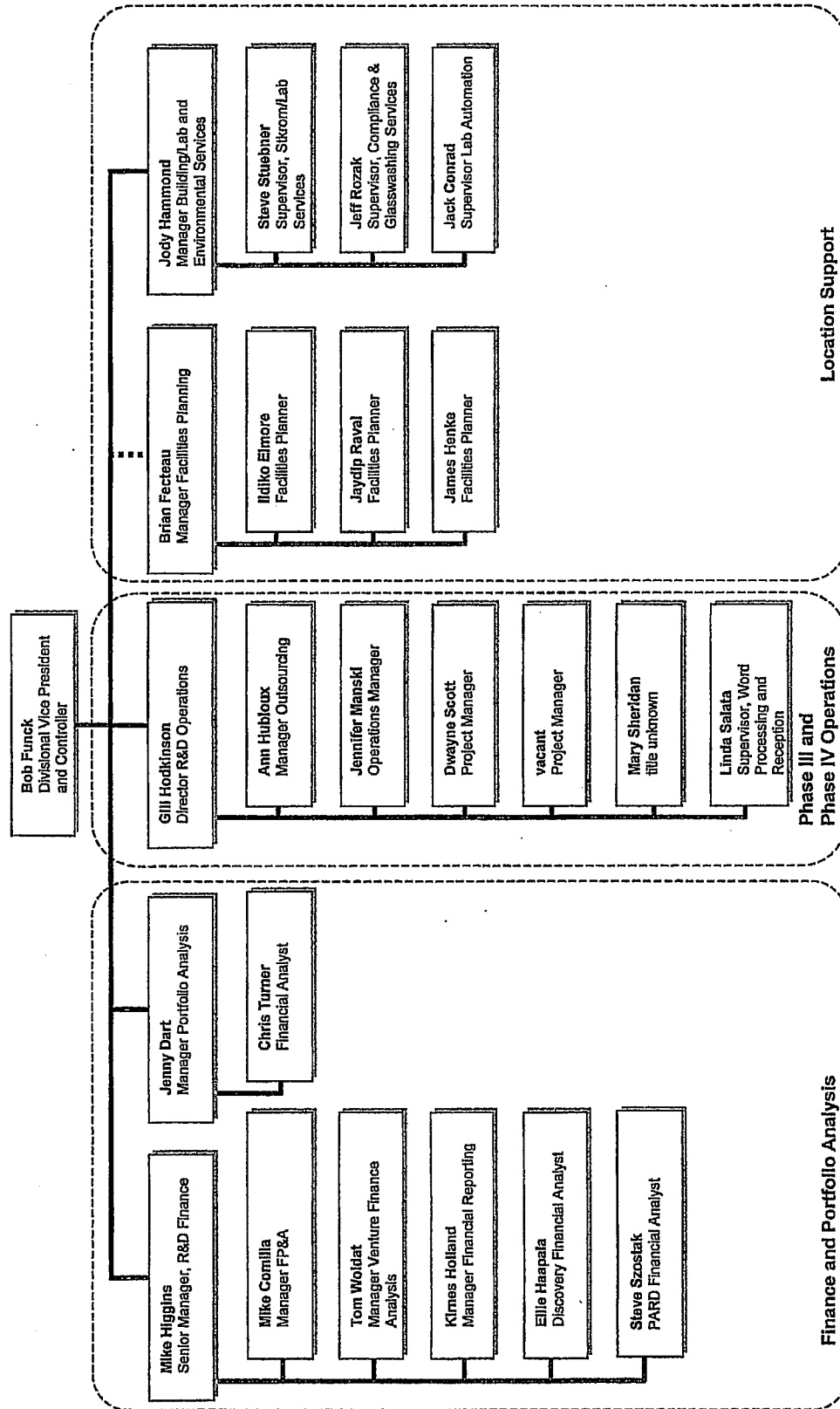
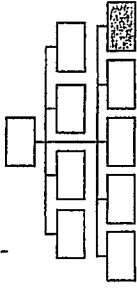


GLOBAL PHARMACEUTICAL LICENSING AND NEW BUSINESS DEVELOPMENT



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GLOBAL PHARMACEUTICAL R&D CONTROLLER'S ORGANIZATION



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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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CH-228011-079j/rcDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5	<div> <ul style="list-style-type: none"> • NC Chemistry • Chemical Development • Special Labs </div>
Abbott International R&D	28.0	
Hospital Products R&D	2.3	
Recent additions to GPD subtotal	62.1	
Abbott Discovery	192.0	
Abbott Development	380.0	
Abbott subtotal	572.0	
TAP & Sister Division	57.0	
Abbott total	629.0	
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x-Knoll other*	34.0	
x-Knoll total	410.0	
R&D total	1,100.9	

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

** International development center

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jb/rcDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D
 Abbott International R&D
 Hospital Products R&D

Recent additions to GPD subtotal

Abbott Discovery
 Abbott Development

Abbott subtotal

TAP & Sister Division

Abbott total

x-Knoll Corp. Discovery
 x-Knoll Corp. Development
 x-Knoll other corporate
 x-Knoll local R&D
 x-Knoll other*

x-Knoll total**R&D total**

31.5	
28.0	
2.3	
62.1	
192.0	
380.0	
572.0	
57.0	
629.0	
130.3	
258.3	
-30.5	
18.0	
34.0	
410.0	
1,100.9	

• IDC**
 • Other
Total

7.7
 23.8
31.5

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

** International development center

Note: x-Knoll data is preliminary

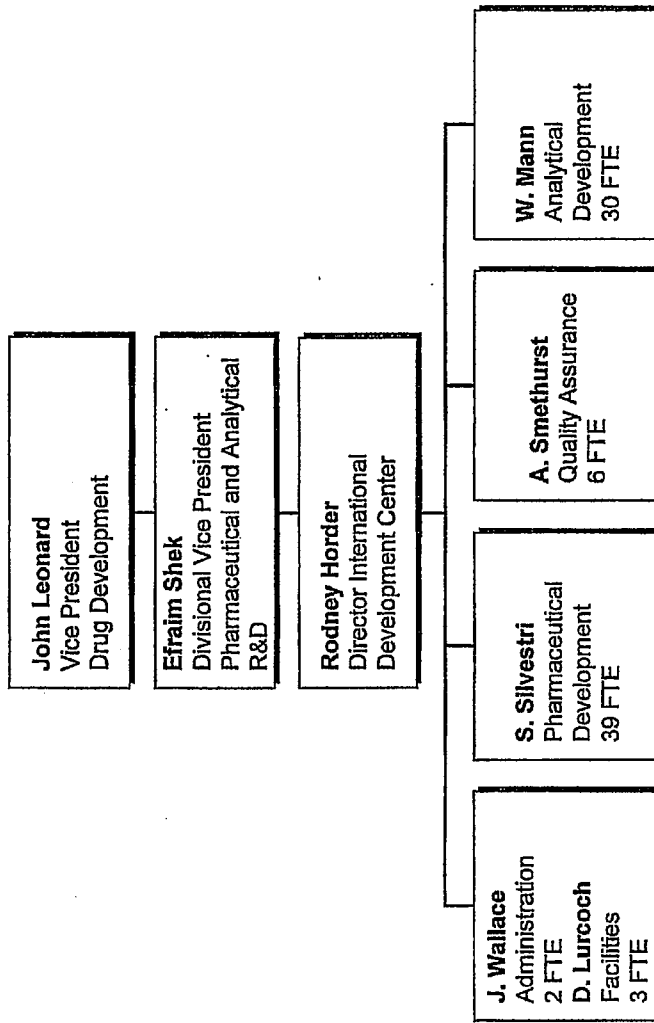
Source: R&D Finance

CH-228011-079jb/rcDC

ABBOTT INTERNATIONAL R&D OVERVIEW

\$ Millions

	<u>Budget</u>	<u>Headcount</u>
IDC	7.7	79
Others	23.8	?
Total	31.5	?

IDC structure**IDC activities**

Formulation development, historically to support Abbott International

IDC budget


Payroll	3.2
Employee related	0.9
Operating	1.6
Fixed	2.0
Total	7.7

Service sold – AI	3.5
Service sold – PPD	3.0
Service sold – other	0.7 (internal costs)

CH-228011-079jb/rbDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5	
Abbott International R&D	28.0	
Hospital Products R&D	2.3	
Recent additions to GPD subtotal	62.1	
Abbott Discovery	192.0	
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x-Knoll total	410.0	
R&D total	1,100.9	

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jb/reDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1

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x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

770 headcount

Cancer	43.0
Infectious Disease	35.4
Metabolic Disease	26.5
Neurological	41.6
Other	45.5
Total	192.0

"Other" includes research in
other TAs

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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2001 ABBOTT DISCOVERY BUDGET OVERVIEW

\$ Millions

Cancer	43.0
Infectious Disease	35.4
Metabolic Disease	26.5
Neurological	41.6
Other	45.5
Total	192.0

770 headcount

Discovery	0.899
Matrix Metalloproteinase	5.157
Urokinase	9.698
Angiogenesis	8.975
Apoptosis	7.783
Farnesyltransferase	1.457
Anti-Mitotic	0.154
Chemotherapeutics	1.129
Cancer Exploration Biology	3.695
Cancer Research Misc.	
Total Cancer Research	42.947
Anti-Viral Research	13.099
Anti-Bacterial Chemistry	13.195
Novel Anti-Bacterial	8.320
Microbiology Research	(1.650)
Infective Dis Research Misc	2.434
Total Infectious Disease	35.399
Diabetes: Cell Biology	7.900
Diabetes: Signal Transduction	7.248
Kera Bp	0.945
Growth Factors	0
Cell Adhesion	0
New Targets	4.080
Metabolic Diseases Misc	5.795
Total Metabolic Disease	26.868
Cholinergic Modulation	6.965
Urological Diseases	7.825
Exploratory Urology	4.557
Purinergic Research	7.286
Expl Neurobiology	4.897
CNS Disease Research	2.468
NUDR Chemistry	0.977
Neurology & Urology Misc	6.989
Total Neurological	41.683
Structural Biology	4.850
Structural Chemistry	1.954
Genomics	4.154
CAMD	0.488
Molecular Services	0.770
Automated/Engineering	2.178
Combinatorial Chemistry	8.240
Biological Screening	3.954
Patent Liaison Services	0
Advanced Technology Misc	1.635
Total Advanced Technology	28.003
Process Chemistry	3.748
Process Research	0.461
Chemical Sciences Misc	1.386
Total Chemical Science	5.595
Ligand	0.361
Immunosuppressants	0
Integrative Pharmacology	2.681
Integrative Pharm Admin	1.006
Total Inte Pharmacology	3.688
Discovery Support	12.040
Other/ODC	(4.173)
Absorption/Discretionary	0
Total Other	7.867
Total	192.000

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CH-228011-079jb/rcDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3

Recent additions to GPD subtotal**62.1**

Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0

TAP & Sister Division**57.0****Abbott total****629.0**

x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0

x-Knoll total**410.0****R&D total****1,100.9**

770 headcount	
Administrative overhead	36,728
Functional	151,593
Internal services sold	-
External services sold	(13,420)
Drug Safety -- Metabolism	6,515
Drug Safety -- Toxicology/Pathology	2,523
Drug Safety -- Comparative medicine	7,969
Drug Safety -- Strategic and Exploratory	468
Phase I Center Clinical	304
Development Operations -- Biostatistics	98
Development Operations -- Research	32
Information Center	
Information Management and Technology	1,946
International Manpower	153
PARC	2,198
Research QA	3
Investigational Drug QA	1
SPD	2,621
Absorption/Discretionary	(7,732)
Total	192,000

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

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CH-228011-079]b/rcDC

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
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x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

1,613 headcount

Neuroscience	40.6
• Depakote	24.1
• Gabitril	1.4
• ABT-594 (CCM)	9.3
• COX-II (ABT-963)	1.2
• ABT-089 (ChCM)	0.6
• RP-Schering/Alza (Hydrocodone)	4.0
Anti Infective	132.3
• Clarithromycin (Blaxin XL)	14.9
• Ketolide (ABT-773)	88.0
• Quinolone (ABT-492)	24.5
• Omnicef	4.9
Urology/cardiology	8.7
• BPH backup (ABT-980)	2.3
• Fenofibrate (Fournier)	1.4
• KCO (potassium channel: ABT-598)	5.0
HIV	57.5
• Ritonavir (Norvir)	4.0
• Kaletra	51.0
• Cyclosporine (Gengraf)	2.5
Cancer	64.6
• Endothelin (ABT-627)	38.8
• TSP No. 1 (ABT-510)	10.0
• Metalloproteinase (ABT-518)	7.4
• Anti-Mitotic (ABT-751)	8.4
Other	42.1
• Misc. R&D**	8.2
• Non-promotional products	11.1
• SPD process	14.2
• SPD excess capacity	11.6
• CRO rebates	(3.0)
Absorption	44.0
• Discovery	4.0
• Drug safety	9.1
• Medical Affairs	1.6
• IM&T	0.6
• Development Ops	4.2
• PARD	7.2
• Reg. Affairs/QA	(0.2)
• Phase I	1.0
• Fixed EVR	2.0
• Overhead burden	4.7
• Misc. fixed	5.0
• Internal	4.8
Affordability	(9.8)
Total Abbott Development	380.0

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"
 ** Includes unallocated floor space/depreciation, etc.

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jb/rcDC

2001 ABBOTT DEVELOPMENT EXTERNAL/INTERNAL

\$ Millions

	External					Total Internal	2001 plan targets
	Grants	SPD materials	PAR material	A.I. grants	Total external		
Neurology							
• Depakote	9.4	-	0.6	-	10.0	14.1	24.1
• Gabitril	-	-	-	-	-	1.4	1.4
• ABT-594 (formerly CCM)	1.1	-	0.2	-	1.3	8.0	9.3
• COX-II	0.1	-	-	-	0.1	1.1	1.2
• ABT-089 (formerly ChCM)	-	-	-	-	-	0.6	0.6
• RP Scherer/Alza (Hydrocodone)	-	-	-	-	-	4.0	4.0
Subtotal Neurology	10.6	-	0.8	-	11.4	29.2	40.6
Anti-Infective							
• Clarithromycin	2.9	0.3	0.3	8.5	12.0	2.9	14.9
• Ketolide	47.4	4.7	1.0	1.7	54.8	33.2	88.0
• Quinolone	5.0	1.9	-	0.2	7.1	17.4	24.5
• Omnicef	3.0	-	-	-	3.0	1.9	4.9
Subtotal Anti-Infective	58.3	6.9	1.3	10.4	76.9	55.4	132.3
Urology/cardiology							
• BPH backup	-	-	-	-	-	2.3	2.3
• Fenofibrate (Fournier)	-	-	-	-	-	1.4	1.4
• KCO	0.4	-	-	-	0.4	4.6	5.0
Subtotal Urology/cardiology	0.4	-	-	-	0.4	8.3	8.7
HIV							
• Ritonavir	1.2	-	-	0.7	1.9	2.1	4.0
• Kaletra	22.6	-	1.5	0.2	24.3	26.7	51.0
• Cyclosporine	1.0	-	-	0.2	1.2	1.3	2.5
Subtotal HIV	24.8	-	1.5	1.1	27.4	30.1	57.5
Cancer							
• Endothelin	19.3	-	0.6	-	19.9	18.9	38.8
• TSP #1	1.6	0.5	0.2	-	2.3	7.7	10.0
• Metalloproteinase	1.1	-	-	-	1.1	8.3	7.4
• Anti-Mitotic	1.1	0.3	0.1	0.3	1.6	6.6	8.4
Subtotal cancer	23.1	0.8	0.9	0.3	25.1	39.5	54.6
Other							
Affordability	0.8	-	-	-	0.8	85.3	86.1
Total development	118.0	7.7	4.5	11.8	142.0	(9.8) 238.0	(9.8) 380.0
Discovery							
	-	-	-	0.1	-	192.0	192.0
Total	118.0	7.7	4.5	11.9	142.0	430.0	572.0 20

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2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
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Recent additions to GPD subtotal	62.1
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Abbott subtotal	572.0
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x-Knoll Corp. Development	258.3
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x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

2,283
headcount

Pharmaceutical Discovery	153.0
Drug Safety	39.0
Medical Affairs	19.0
Information Management & Technology	50.0
Development Operations	17.0
Venture Management	34.0
Administration	20.0
Pharmaceutical Analytical Research & Development	59.0
Regulatory Affairs/Quality Assurance	9.0
Phase I Center	10.0
Functional Subtotal	410.0
Clinical Grants	118.0
Services purchased*	47.0
SPD services purchased	53.0
Other	0.4
Total	629.0

* About \$40 million from within Abbott (e.g., legal)

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jbrdc

ABBOTT DISCOVERY AND DEVELOPMENT FUNCTIONAL GROUPS

Function	2001 budget (\$ Millions)	Headcount	Leader	Description
Pharmaceutical discovery	153	770	Dan Norbeck, VP	Conducts research activities that lead to development of selected products
Drug safety	39	189	Reid Patterson, DVP	Chemists and biologists researching drug absorption, metabolism, damage, etc.
Medical Affairs	19	137	Dave Pizzutti, DVP	Continued development of PPD marketed products, including formulation development, label expansion, and market driven. Also post-marketing safety
Information management and technology	50	257	Bob Hogan	IT resource management, training, and support. Maintains system, develops customer applications
Development operations	17	181	Mike Rubison*, Group Director	Supports development of databases, report generation, and statistical analysis
Venture management	34	169	John Leonard, VP	Venture teams that provide a core group of individuals with expertise in particular therapeutic areas. Responsible throughout development
Administration	20	113	Jeff Leiden, EVP	Support functions, such as finance, HR, engineering, and executive R&D management
Pharmaceutical Analytical Research & Development	59	337	Efraim Shek, DVP	Develops new products using analytical methods, manufactures for clinical trials, supports existing products
Regulatory Affairs/ Quality Assurance	9	68	Mick Roebel, DVP	Overall regulatory support such as FDA licensing, regulatory submission, oversight of clinical work and toxicology
Phase I center, clinical pharmacology and pharmacokinetics	10	62	Rick Granneman, Director	Facility at VMH and other functions
Total	410	2,283		

* Rubison reports to Granneman

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ABBOTT VENTURES

Pharmaceutical Discovery	153.0
Drug Safety	39.0
Medical Affairs	19.0
Information Management & Technology	50.0
Development Operations	17.0
Venture Management	34.0
Administration	20.0
Pharmaceutical Analytical Research & Development	59.0
Regulatory Affairs/Quality Assurance	9.0
Phase I Center	10.0
Functional Subtotal	410.0
Clinical Grants	118.0
Services purchased*	47.0
SPD services purchased	53.0
Other	0.4
Total	629.0

	2001 plan (\$ Millions)	Headcount	VP OF TA
Anti-infective	8.7	42	E. Sun
Anti-viral	10.5	55	E. Sun
Analgesia	5.8	11	?
Urology	2.0	14	M. Verlinden
Oncology	7.4	47	P. Nisen
Total	34.0	169	

CH-228011-079jb/rcDC

2001 R&D BUDGET OVERVIEW

\$ Millions

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x-Knoll local R&D	18.0
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x-Knoll total	410.0
R&D total	1,100.9

Integrin alpha-v-B3-inhibitors	6.1
PAI-1 mAb	4.0
Calpain inhibitor	11.1
T-cell PTK inhibitors	7.0
KDR-inhibitors	5.3
ICE-inhibitors	7.7
Oral thrombin inhibitors	11.8
ET receptor antagonists	6.7
Anti IL-18 mAb	11.8
PARP inhibitors	9.6
5HT1A receptor ligands	1.9
NIK inhibitors	6.0
Complement inhibitors	13.3
Bujard-Colaboration	(1.3)
Tie-2 inhibitors	4.5
Exploratory Research	4.5
Exploratory Research O/I	8.3
Other corporate research	12.0
Total	130.0

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079j/rcDC

KNOLL DISCOVERY SPEND BY LOCATION

Percent of project budget

Project	BASF	Knoll AG	KPC	KP UK	ABC	Italy	Spain	LKF	Canada	Japan	KJJK	Knoll BV	Belgium	Australia
Integrin alpha-v-B3-inhibitors		100												
PAI-1 monoclonal antibody		65			35									
Calpain inhibitor		100												
T-cell PTK inhibitors					99									
KDR-inhibitors					81		19							
ICE-inhibitors		19			79									
Oral thrombin inhibitors	1	99												
ET receptor antagonists	1	99												
anti IL-18 mAB		10			90									
PARP inhibitors		100												
5HT _{1A} receptor ligands		100												
NIK inhibitors					100									
Complement inhibitors	1	96			2									
Bujard-Colaboration		100												
Tie-2 inhibitors		2			98									
Exploratory Research		100												
Exploratory Research O/I					100									
Other corporate research										1				

CH-228011-079jb/rcdc

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

BSF 302146 (LU302146)	4.2
HSR-903	
T3/T4	9.3
Hokunalin tape	
Darusentan (LU 135252)	26.4
LU208075	4.5
PEG-Hirudin	21.4
Ancrod	1.0
BSF 201640	(2.3)
BSF 74398 (Parkinson)	
Dilaudid OROS	12.7
BSF 190555 (Schizophrenia)	
AU224	4.1
D2E7	98.2
SEGARD	11.7
J695	14.2
Clivarine	3.6
Meridia (Sibutramine)	21.8
Trandolapril (patch, intervention trials)	
LU420627 (BSF 420627)	4.8
Propafenone-HCL (Rythmol SR)	9.2
Corp. Development non TA	13.5
Total	258.3

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jbr/cDC

KNOLL 2001 PLAN DEVELOPMENT SPEND INTERNAL/EXTERNAL

\$ Millions

	Total	Internal	External	Depreciation
• BSF 302146 (LU302146)	4.2	3.9	0.3	
• HSR-903				
• T3/T4	9.3	4.5	4.8	
• Hokunalin tape				
• Darusentan (LU 135252)	26.4	12.9	13.5	
• LU208075	4.5	3.2	1.3	
• PEG-Hirudin	21.4	8.1	13.3	
• Ancrod	1.0	0.3	0.7	
• BSF 201640	(2.3)	(2.1)	(0.2)	
• BSF 74398 (Parkinson)				0.9
• Dilaudid OROS	12.7	5.9	5.9	
• BSF 190555 (Schizophrenia)				
• AU224	4.1	2.3	1.8	
• D2E7	98.2	48.1	49.7	0.4
• SEGARD	11.7	5.9	5.8	
• J695	14.2	7.7	6.3	0.2
• Clivarine	3.6	1.8	1.8	
• Meridia (Sibutramine)	21.8	11.0	10.8	
• Trandolapril (patch, intervention trials)				
• LU420627 (BSF 420627)	4.8	4.1	0.7	
• Propafenone-HCL (Rythmol SR)	9.2	5.6	3.6	
• Corp. development non-TA	13.5	11.5	2.0	
Total	258.3	134.8	122.0	1.5

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CH-228011-079jb/rcDC

KNOLL DEVELOPMENT SPEND BY LOCATION

Percent of project budget

Project	BASF	Knoll/AG	KPC	KP UK	ABC	Italy	Spain	LKF	Canada	Japan	KJ/KK	Knoll BV	Belgium	Australia
BSF 302146 (LU302146)														
HSR-903														
BSF 420627 (ETA/BPH)														
T3/T4			100											
Hokunalin tape														
Danuserentan (LU 135252)		66	33			1								
LU208075 (endothelin antagonist)	2	93				2								
PEG-Hirudin		40	57	1					2					
Ancrod (Viprinex)		100												
BSF 201640		96	4											
BSF 74398 (Parkinson)														
Dilaudid OROS		18	42	40										
BSF 190555 (Schizophrenia)														
Ganaton (pro-kinetic)														
TU-199 (proton pump inhibitor)														
AU-224 (colon pro-kinetic)		20								80				
D2E7		20	49	3	19	1	1	1	2	2	1	1		1
SEGARD		48	50		2									
J695		6	63		31									
Clivarine		64							3		33			
Meridia (Sibutramine)		16	33	34						9	9			
Trandolapril (patch, intervention trials)														
LU420627	4	94				2								
Propafenone-HCL		26	72	1		1								
Corp. Development non TA	27					10	2	2		59				

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MCK 00304

CH-228011-079jbrcdc

2001 R&D BUDGET OVERVIEW

\$ Millions

Specialty Products R&D	31.5
Abbott International R&D	28.0
Hospital Products R&D	2.3
Recent additions to GPD subtotal	62.1
Abbott Discovery	192.0
Abbott Development	380.0
Abbott subtotal	572.0
TAP & Sister Division	57.0
Abbott total	629.0
x-Knoll Corp. Discovery	130.3
x-Knoll Corp. Development	258.3
x-Knoll other corporate	-30.5
x-Knoll local R&D	18.0
x-Knoll other*	34.0
x-Knoll total	410.0
R&D total	1,100.9

	Discovery	Development	Other	Total
BASF	0.4	4.3	-	4.7
Knoll AG	69.9	75.0	8.8	153.7
KPC	-	112.0	-	112.0
KP UK	-	15.3	-	15.3
ABC	46.9	23.1	6.9	76.9
Italy	-	2.3	-	2.3
Spain	1.0	1.0	-	2.0
LHF	-	1.3	-	1.3
Canada	-	2.6	-	2.6
Hokurihu	12.0	14.7	-	26.7
KJHK	-	3.8	-	3.8
NL	-	1.0	-	1.0
Belgium	-	0.6	-	0.6
Australia	-	1.2	-	1.2
Correction	-	-	(46.2)	(46.2)
Total	130.3	258.3	(30.5)	358.1

May not match actuals,
Ludwigshafen internals
50, not 60

* Phase III/IV (U.S. only), U.S. and international medical affairs, ABC D2E7 "start-up"

Note: x-Knoll data is preliminary

Source: R&D Finance

CH-228011-079jbr/cdc

MARCH 5, 2001**EMPLOYEES BY FUNCTIONAL AREA - LUDWIGSHAFEN**

Function	Headcount	FTEs	Temp	Exempt headcount	Non-exempt headcount
Discovery Research Head Office	4	3.8	0	1	3
Biochemical Biology	24	20.8	0	0	25
Medicinal Chemistry	59	53.8	2	13	43
High Throughput Screening	16	16.8	1	4	14
Compound analytics for HTS	7	6.2	0	1	6
Compound library & dispensation	9	7.9	1	0	9
Research Services (dish wash & shop)	25	22.2	1	1	24
Molecular Biology	25	23.4	0	5	20
Pharmacology	25	23.4	0	14	11
TEI systems	2	2.0	2	1	0
Discovery Research	255	235.0	6	51	204
Pharmaceutical Centers Head Offices	9	8.8	0	3	6
Chemical Process Development	25	24.5	1	5	20
Chemical Analytical Development	8	7.2	0	2	6
Radiochemistry	5	5.0	0	3	2
Journals	2	2.0	0	0	2
Radionuclide (legally required)	1	1.0	0	1	0
Analytical Development	15	14.0	0	3	12
Animal Studies	11	10.0	0	2	9
Formulation Development Opd	15	15.0	2	6	8
Formulation Development Pharmaceuticals	16	13.8	1	4	11
Bioanalytics	27	23.8	2	8	19
Formulation Development * Kinetics	23	21.0	1	8	17
Drug Deposition	13	12.6	1	4	9
Early ADME	4	4.0	1	2	2
Project Technology	4	3.8	1	1	3
Exp. & Cell Technology & Pathology	7	6.6	1	1	6
Clinical Development	22	22.0	0	0	22
Biorescience Facility (ARF)	239	227.0	11	59	180
Pharmaceutical Centers	29	27.0	1	10	18
Clinical Dev. CV	21	20.2	2	6	13
Clinical Operations	1	1.0	0	1	0
Clinical Pharmacology	17	17.0	0	1	16
Global Projects & Chair Pharm Biostat.	7	6.8	0	3	4
Clinical Biostatistics	8	8.8	2	4	5
Clinical Data Management	25	22.2	1	7	18
Clinical Centers	111	103.0	12	41	70
Global Projects Head Office & CTLs	4	4.0	0	3	1
Project Management	5	5.0	0	3	2
Project Coordination	5	4.5	0	1	4
Global Projects	14	13.5	0	7	7
Reg Affairs Head Office & Labeling	4	4.0	0	3	1
Electronic Document Management	2	1.8	0	1	1
Quality Assurance GTP	8	8.0	0	4	4
Desktop Production & Reg. Compliance	5	5.0	0	3	2
Language Services (Translation)	5	4.2	0	1	4
Scientific Document Service	2	2.0	0	1	1
Strategic Reg Affairs	3	3.0	0	2	1
Quality Support	8	8.0	0	3	7
Pharmacoepidemiology	10	8.2	0	4	6
Regulatory Centers	48	46.0	0	22	26
SPS Head Office/Animal Serv./ACRO Mgmt.	6	6.0	0	1	5
Lab supplies	3	3.0	0	0	3
Information Services Head Office	3	2.2	0	1	2
Library & Literature Services	5	4.6	2	1	4
Library & Literature Services	6	6.4	2	2	5
Depository Mgmt. & High Security Archive	4	4.0	1	4	11
Bioprocess Development	16	13.0	0	4	11
Biochemical non-clinical	4	4.0	0	2	2
Research IT	4	4.0	0	0	4
R&D Controlling <non R&D HC>	<5>	<4.2>	<0>	<0>	<5>
Systems, Processes & Support	52	47.6	5	12	40
Total R&D Knoll AG	719	672.0	34	192	527

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Appendix

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BUDGET BY THERAPEUTIC AREA

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comment
Anti-Infective	• Clarithromycin (Blaxin)	Abbott	C	IV	Y	14.9	S	Antibiotic
	• ABT 492 (Quinolone)	Abbott	C	I	Y	24.5	S	Respiratory antibiotic
	• ABT 773 (Ketolide)	Abbott	C	III	Y	88.0	S	Antibiotic; bronchitis
	• HSR 903	Knoll	T	III	Y	0.0	S	Quinolone antibiotic
	• Omnicef	Abbott	C	IV	Y	4.9	S	Cephalosporin antibiotic
Anti-viral	• Triangle projects (HIV and HBV)	Abbott JV	?	?	N	?	S	
	• Kaletra	Abbott	C	IV	Y	51.0	S	Protease inhibitor
	• Norvir (ritonavir)	Abbott	C	IV	Y	4.0	S	Protease inhibitor
Asthma	• Hekunilintape (tulobuterol)	Knoll	P	Pre-clinical	Y	0.0	S	(Beta-2) agonist/asthma
Cardiology	• ABT 187 (r-proUK; recombinant protein)	Abbott	C	III	Y	0.0	B	Acute stroke
	• Urokinase	Abbott	C	III	Y	0.0	B	?
	• Ancrod (Viprinex)	Knoll	T	III	Y	1.0*	B	Acute ischemic stroke
	• Cilvarine	Knoll	C	IV	Y	3.6	B	LMW heparin; thrombosis
	• Darusentan (LU 135252)	Knoll	H	II/III	Y	26.6	S	Endothelin A antagonist
	• Levosimendan (simdax)	Abbott	C	IV	Y	0.0	?	Calcium sensitizer
	• LU208075 (BSF 208075)	Knoll	H	I	Y	4.2	S	Congestive heart failure
	• PEG-Hirudin (pegmusirudin)	Knoll	P	II	Y	16.0	B	Thrombin inhibitor
	• Rythmol SR (propafenone)	Knoll	C	III/IV	Y	9.2	S	Anti-arrhythmic
	• Trandolapril (patch, intervention trials)	Knoll	P	I		0.0	S	Transdermal ACE inhibitor

Source: R&D finance; Development Review templates; team analysis

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BUDGET BY THERAPEUTIC AREA (CONTINUED)

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comments
Endocrine	• T3/T4	Knoll	P	Pre-clinical IV	Y	9.3	B	Hypothyroidism
	• Meridia (Sibutramine)		H		Y	21.8	?	?
Gastroenterology	• AU 224 (colon pro-kinetic)	Knoll	C	I	Y	4.1	S	Chronic constipation
	• Ganaton (pro-kinetic)	Knoll	P	II	Y	0.0	S	Gastric Dismotility,
	• TU-199	Knoll	T	IV (Japan)	Y	0.0**	S	Proton pump Inhibitor
Immunology	• D2E7 (adalimumab)	Knoll	C	III	Y	98.2	B	Arthritis; anti-TNF alpha mAb
	• J695	Knoll	P	II	Y	14.2	B	Anti-IL12 mAb; arthritis
	• SEGARD	Knoll	H	III	Y	11.7	B	Sepsis
Metabolic	• Fenofibrate (Fournier strico)	Abbott	C	IV	Y	1.4	S	Hypertriglycerodeml a
	• Uprima	TAP/ Abbott	C	IV	Y	0.0***	S	Erectile dysfunction
Neuroscience	• Gabatril	Abbott	?	IV	N	1.4	?	GABA uptake inhibitor
	• ABT 598 (KCO)	Abbott	?	I	N	5.0	?	Overactive bladder
	• ABT 594 (CCM)	Abbott	P	II	Y	9.3	S	Diabetic pain
	• ABT 963 (Cox-II)	Abbott	C	I	Y	1.2	S	Osteoarthritis
	• Bimocromol (ABT 822)	Abbott	P	II	Y	0.0	?	Diabetic neuropathy
	• ABT 089	Abbott		I	N	0.6	S	Alzheimers
	• BSF 201640	Knoll	P	III	Y	(2.3)	S	Schizophrenia
	• BSF 74398 *	Knoll	C	II	Y	0.0	S	Parkinson's
	• BSF 190555	Knoll	P	III	Y	0.0	S	Schizophrenia
	• Dilaudid Oros (Hydromorphone SR)	Knoll	H	IV	Y	12.7	S	To treat pain
	• Depakote	Abbott	C	IV	Y	24.1	S	Epilepsys migraine
	• Hydrocodone (RP Scherer Alza)	Abbott	C	I	Y	4.0	S	Acute pain

* Cancelled

** May be funded by locally

*** May be funded by AI

Source: R&D finance; Development Review templates; team analysis

CH-228011-079jbr/cDC

BUDGET BY THERAPEUTIC AREA (CONTINUED)

Therapeutic area	Project	Origin	Priority	Phase	Reviewed	2001 plan	(S) small molecule (B) biological	Comments
Oncology	• ABT 510 (Tsp. no. 1)	Abbott	C	I	Y	10.0	S	Solid tumors
	• ABT 751 (anti-tubulin)	Abbott	C	I	Y	8.4	S	Solid tumors
	• ABT 627 (endothelin)	Abbott	C	III	Y	38.8	S	Prostate cancer
	• ABT 518 (metallo-protease)	Abbott	H	I	Y	7.4	S	Solid tumors
	• Rubitecan	Abbott (HPD)	P	III	Y	0*	S	Topoisomerase I inhibitor
	• Theragyn	Abbott (HPD)	P	III	Y	0*	B	Ovarian cancer (mAb)
Urology	• BSF 420627 (ETA/BPH)	Knoll	P	I	Y	4.8	S	Benign prostate hyperplasia
	• ABT 980 (BPH backup)	Abbott		Killed		2.3	S	Benign prostatic hyperplasia
Other	• Gengraf (Cyclosporine)	Abbott	C	IV	Y	0	S	Immuno-suppressant
	• BSF 302146	Knoll	?	?	N	4.2	?	?
	• Norvir		C		Y			
	• ABS 103/NRS 1776	Abbott			N			
	• ABT-677 (Nevraminidase)	Abbott			N			
	• ABT-828 (45)	Abbott			N			
	• FTI	?						
	• Ritonovir	?						
	• TSP-2	?						

* May be funded by HPD

Source: R&D finance; Development Review templates; team analysis

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POTENTIAL SAVINGS FROM TERMINATING DEVELOPMENT PROJECTS

\$ Millions

PRELIMINARY

Program name	Priority	2001 potential savings (external only)	2001 planned budget \$ Millions		2001 budget if killed mid-May \$ Millions	
			External	Internal	External	Internal
ABT-518 (MMPI)	Terminate	0.90	1.10	8.30	9.40	4.40
Darunavir	Terminate	10.57	13.50	12.90	26.40	9.77
Dolutegravir	Terminate	2.85	5.90	5.90	12.70	?
SEKID	Terminate	2.80	5.80	5.90	11.70	?
T3/T4	Pending	2.40	4.80	4.50	9.30	?
ABT-594	Pending	0.24	1.30	8.00	9.30	8.71
J895	Pending	(0.30)	6.30	7.70	14.00	10.20
PEG Hirudin	Pending	6.65	13.30	8.10	21.40	?
ABT-492 (Quinolone)	Continue	5.00	7.10	17.40	24.50	9.10
ABT-510 (TSP-1)	Continue	2.10	2.30	7.70	10.00	6.10
ABT-627 (Endothelin)	Continue	17.80	19.90	18.90	38.80	14.70
ABT-751 (Anti-Mitotic)	Continue	1.60	1.80	6.60	8.20	3.50
ABT-773 (Ketolide)	Continue	21.70	54.80	33.20	88.00	60.40
ABT-963 (COX-II)	Continue	(0.03)	0.10	1.10	1.20	1.23
AU224	Continue	0.30	1.80	2.30	4.10	1.90
Clarithromycin	Continue	4.70	12.00	2.90	14.90	10.60
D2E7	Continue	0.90	1.80	1.80	3.60	?
Depakote	Continue	24.85	49.70	48.10	97.80	?
Fenofibrate	Continue	4.50	10.00	14.40	24.40	16.10
Hydrocodone	Continue	-	-	1.40	1.40	1.40
Kaletra	Continue	-	-	4.00	4.00	?
Ornithine	Continue	8.00	24.30	26.70	51.00	33.40
Propafenone SR	Continue	2.90	3.00	1.90	4.90	1.60
Sibutramine	Continue	1.80	3.60	5.60	9.20	?
Gengraf	Continue (?)	3.50	10.80	11.00	21.80	11.50
	Continue	(0.20)	1.20	1.30	2.50	2.10
ABT-103/NPS1776	Not reviewed	-	-	-	-	0.20
ABT-089 (ADHD)	Not reviewed	-	-	0.60	0.60	0.60
ABT-598 (KCO)	Not reviewed	0.40	0.40	4.60	5.00	1.40
Ritonavir	Not reviewed	0.80	1.90	2.10	4.00	3.20

Note: Assumes savings of 50% of external costs if project team did not answer survey; shows only projects funded in 2001 PPD and Knoll plans: unfunded projects listed as terminate/hold include Trandolapril, HSR903, and Andro; unfunded projects listed as pending include Rubitecan, Theragyn, Urokinase, BSF-190555, ABT-822, LU420627, Ganaton, and Hukunalin Tape; unfunded projects listed as continue include BSF-190555, Levosimendan, Pro-urokinase, Norvir, and Uprima.

Source: R&D Finance survey of project teams

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MODEL "MAY 8" PORTFOLIO

	Theoretical portfolio including biologicals	Potential total*	Projects in potential total that were not funded in 2001 plans	Projects in potential total currently funded	Current Biologicals (all funded)	Theoretical portfolio without biologicals
Pre-Phase I	8	1**	0	1**	1	7**
Phase I	6	12	2	10	0	6
Phase II	12	9	3	6	2	10
Phase III	5	11	3	8	6	3***
Phase IV – clinical	5	12	3	9	0	5
Phase IV – other	12	–	–	–	–	12
Total	48	44	11	34	9	43
Total (I-IV)	40	43	11	33	8	36
Total (I-IV-clinical)	28	43	11	33	8	24

* All projects considered in development review
 ** Most pre-Phase I not funded in development budget
 *** Not additive

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DRAFT**"IDEAL" PIPELINE**

	Dollars Percent	Success rate Percent	NCE Percent	Number of projects steady-state
Pre-phase I	9	17	37	5.9
Phase I	14	25	17	2.8
Phase II	40	33	26	4.2
Phase III	37	65	19	3.2
Total				16.1

Note: Excludes phase IV. Assumes 1 NDA every 17 months. Phase I is after DDC, before first in man
Source: Abbott portfolio model

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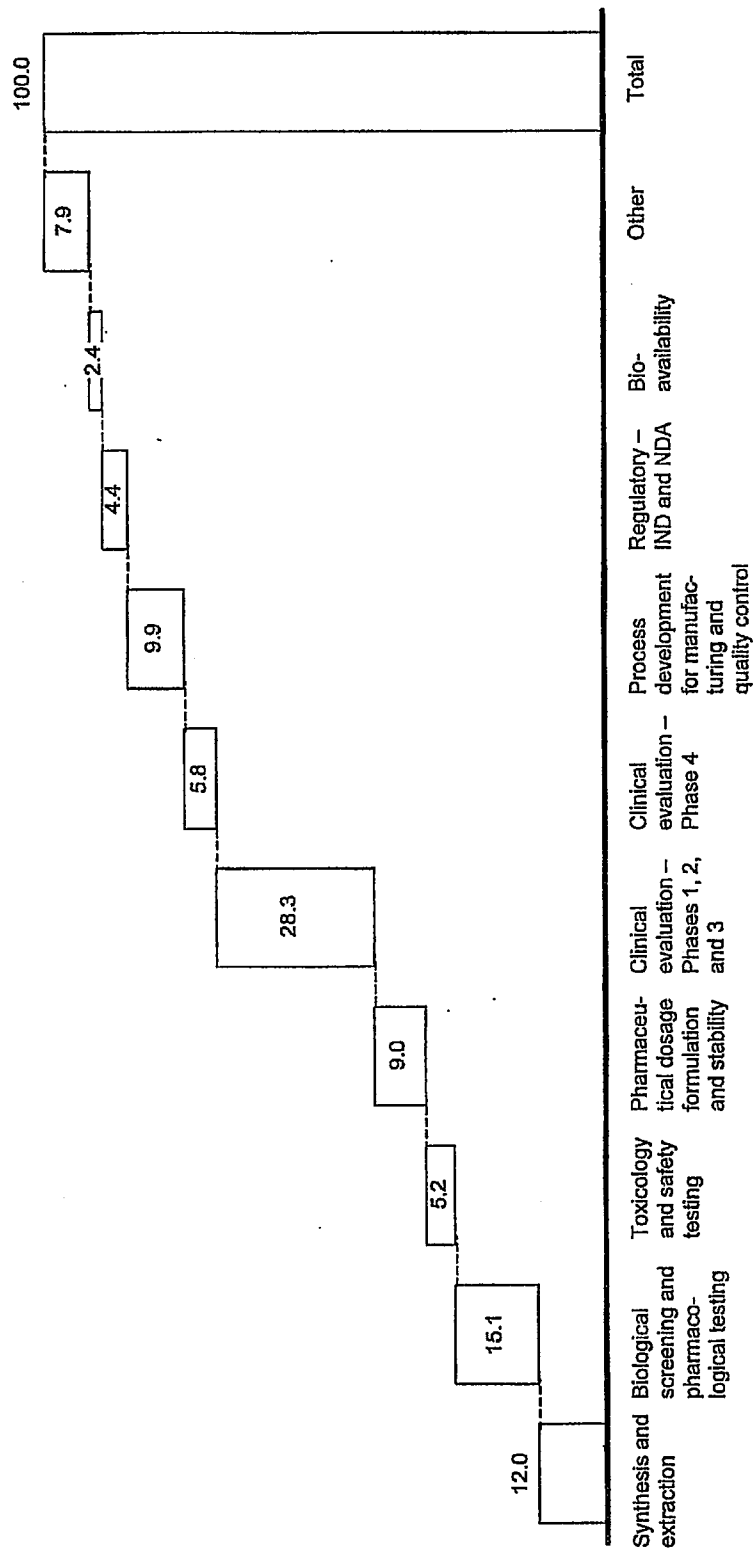
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CH-228011-079jbrdC

ALLOCATION OF DOMESTIC R&D EXPENDITURES BY FUNCTION – 1998

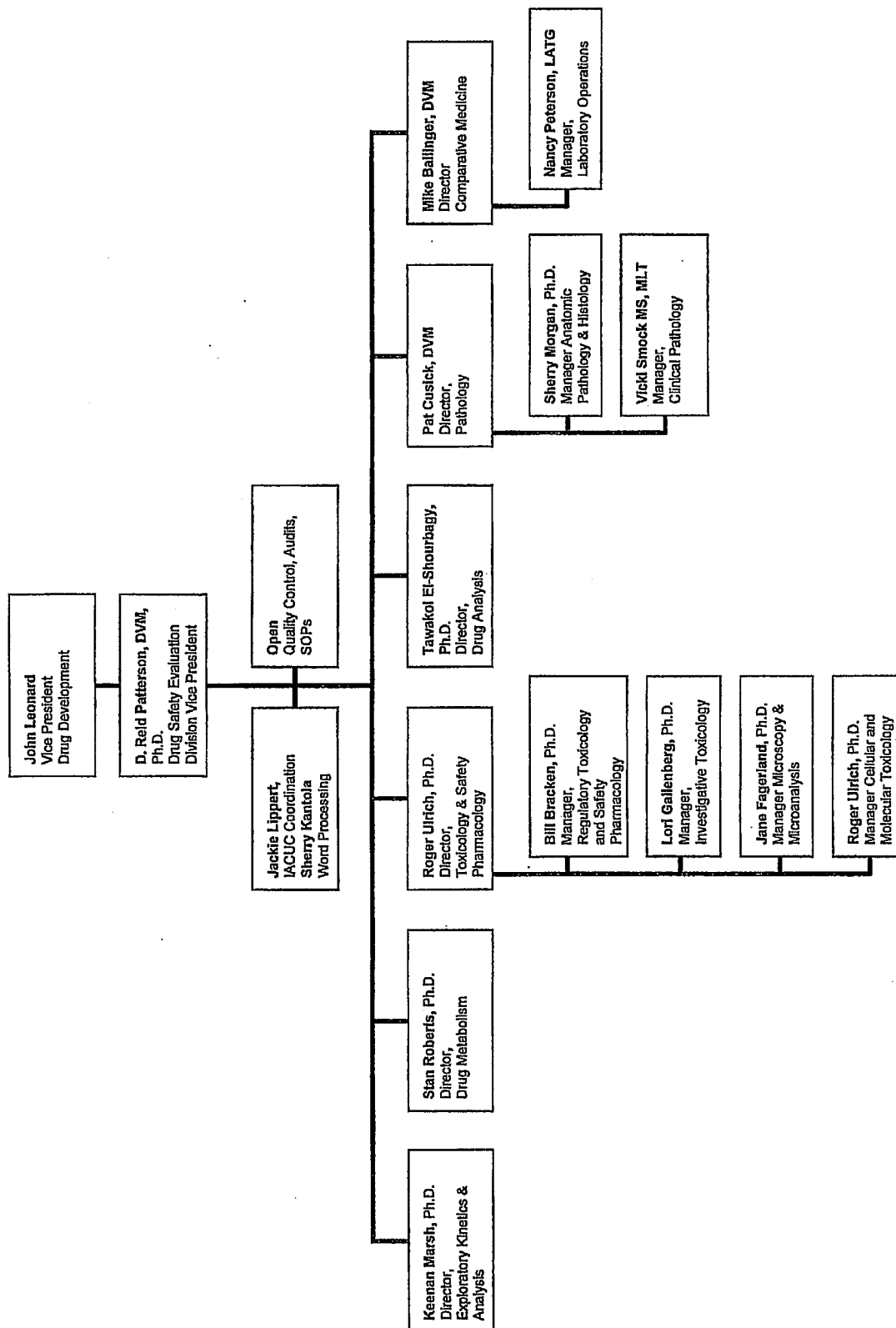
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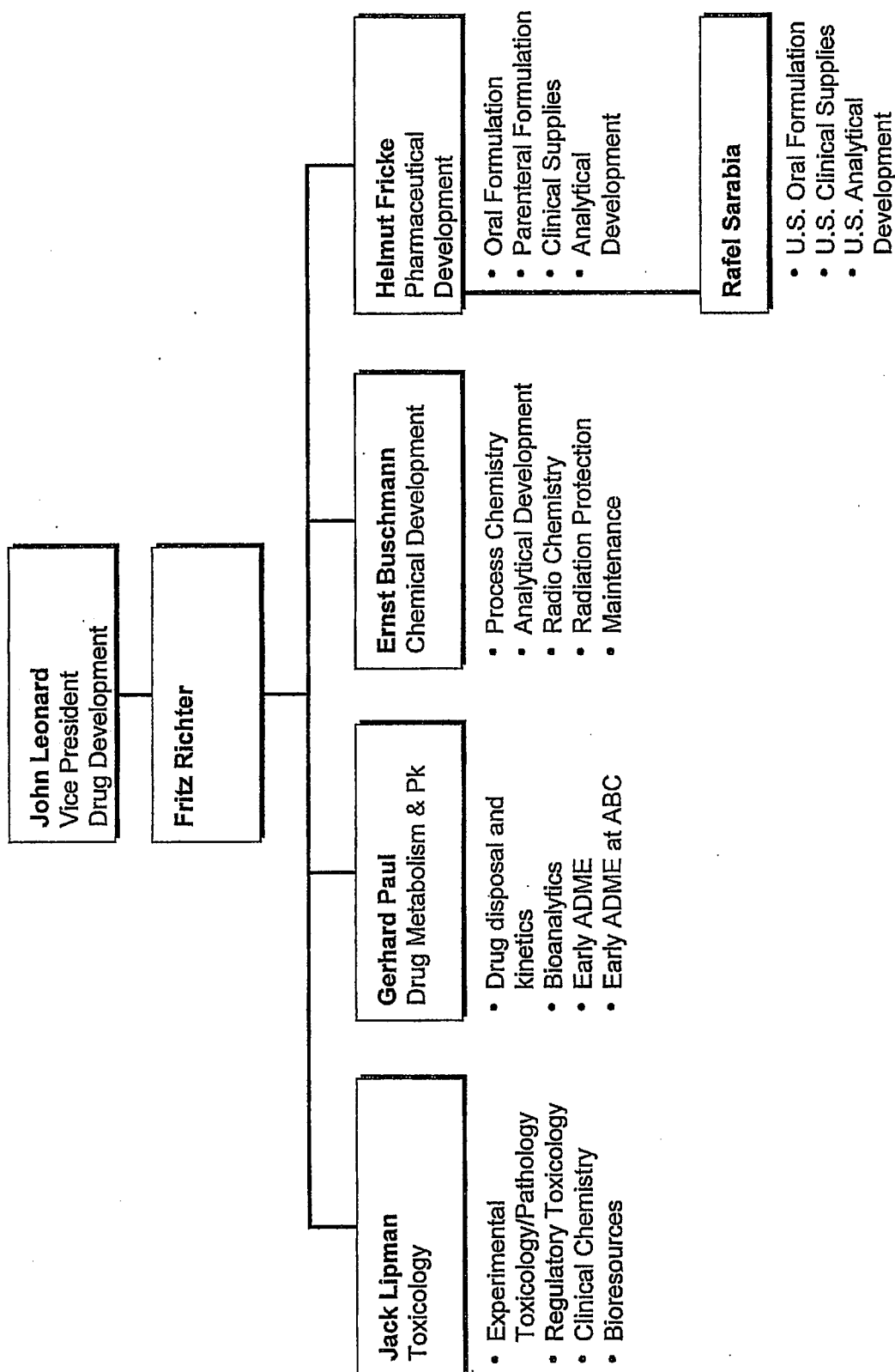
Source: PhRMA, 2000

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ABBOTT TOXICOLOGY

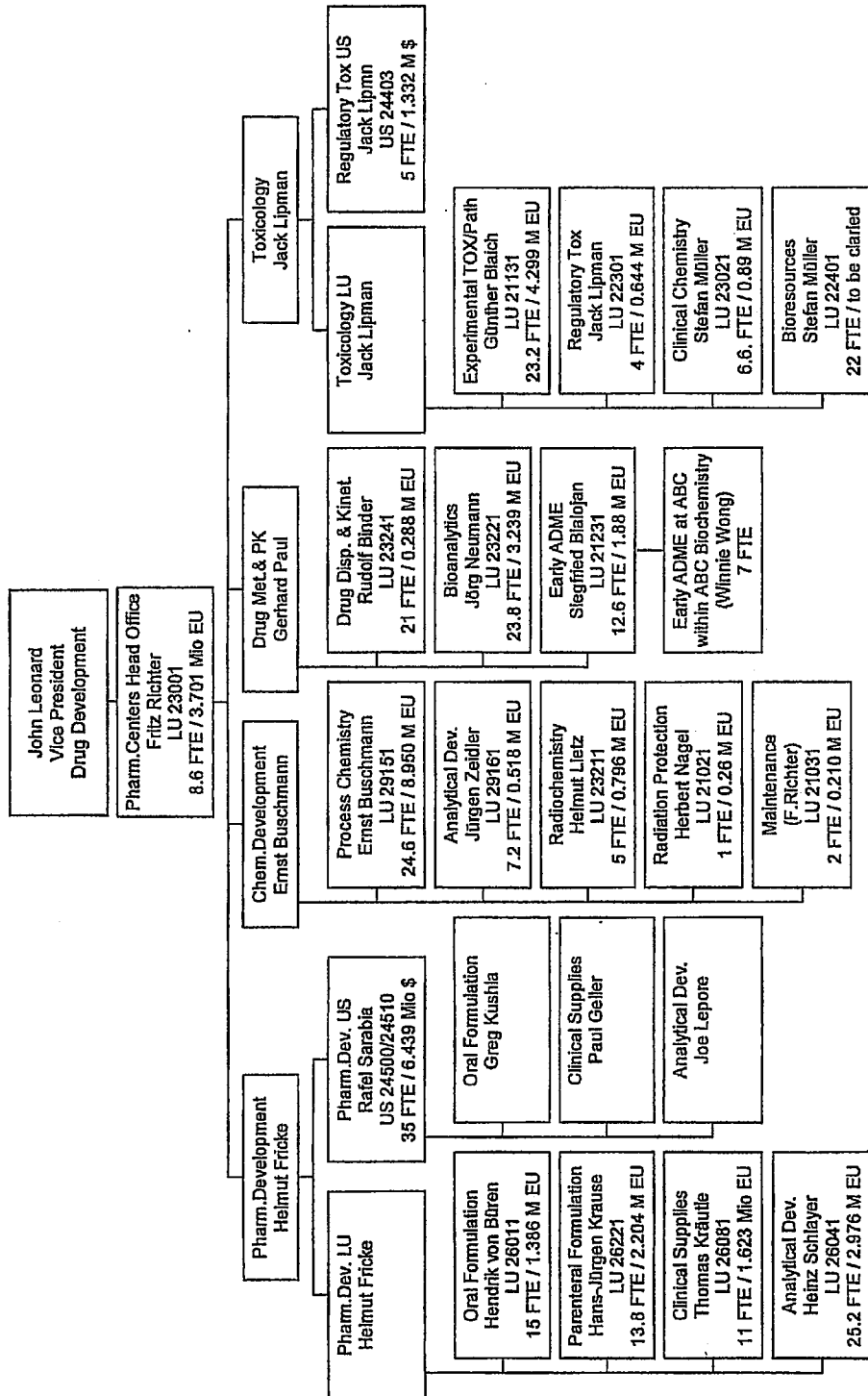
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MARCH 2001**X-KNOLL PHARMACEUTICAL CENTERS**

CH-228011-079jbr/dc

MARCH 2001**X-KNOLL PHARMACEUTICAL CENTERS**

FTE, millions Euro



1 # FTE is effective headcount on board March 5, 2001

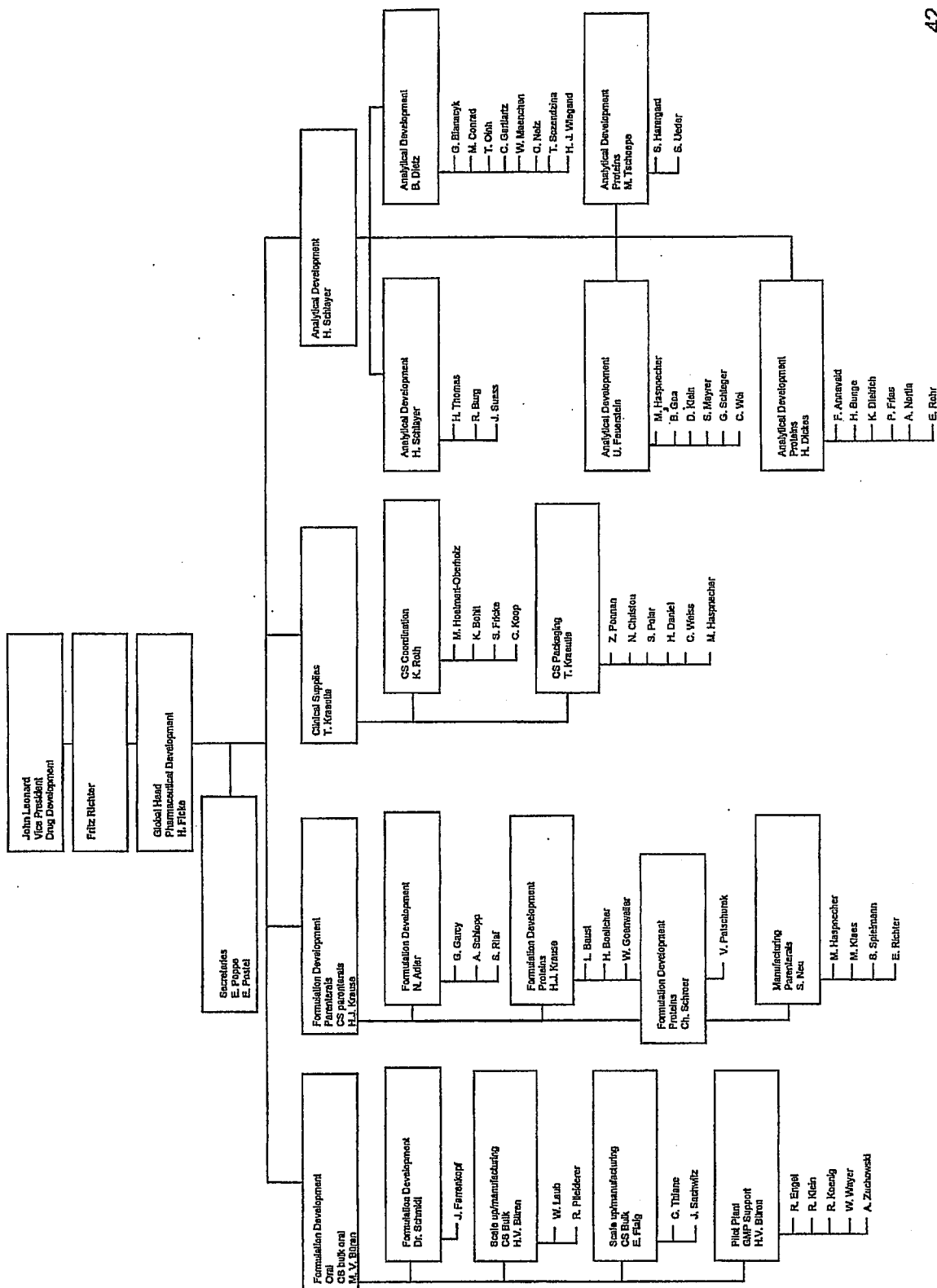
2 Budget figures don't include allocations by central functions e.g. HR, Site infrastructure, other central services

3 Cost distribution between 26011 and 26081 not accurate since recently some FTE + Equipment were moved from one to the other group which is not yet reflected in the budget

4 Budget of head office contains all administrative/management personnel incl. Department heads and several central costs e.g. temporary personnel, space, consultancy, depreciation on tangible assets

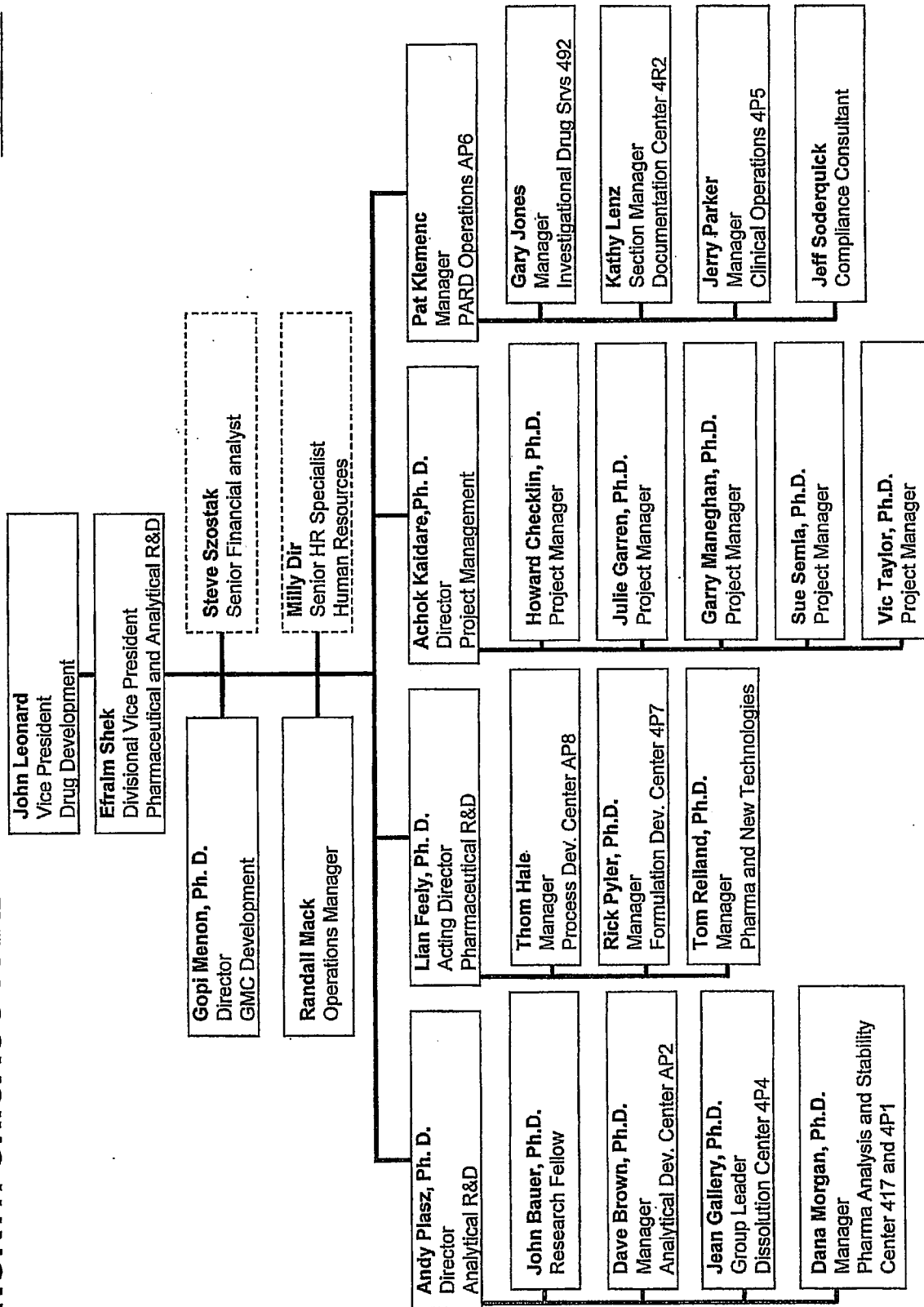
CH-228011-079j/rdDC

X-KNOLL PHARMACEUTICS DEVELOPMENT



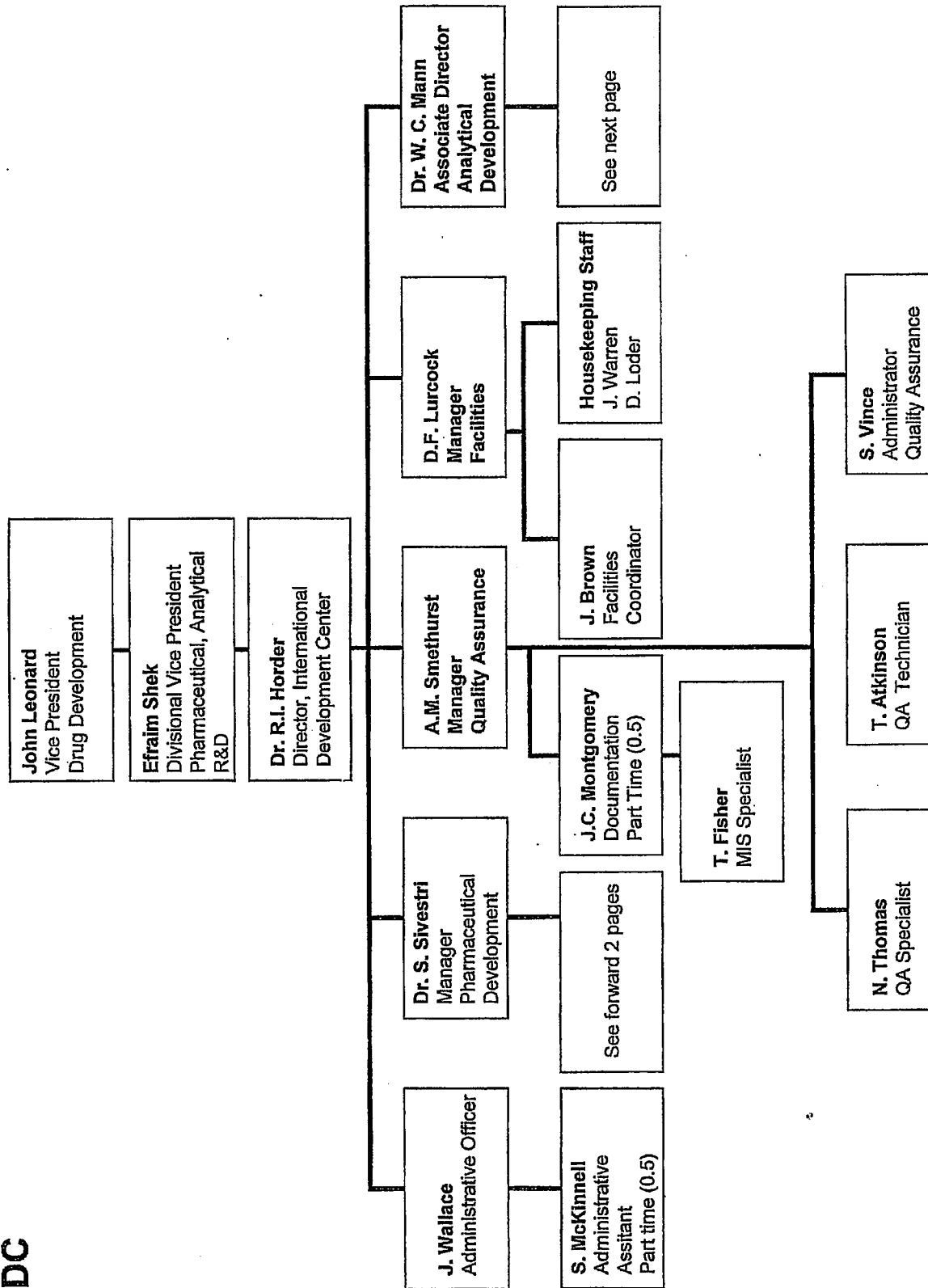
42

CH-228011-079jbrcdc

OUTDATED**NORTH CHICAGO PARD**

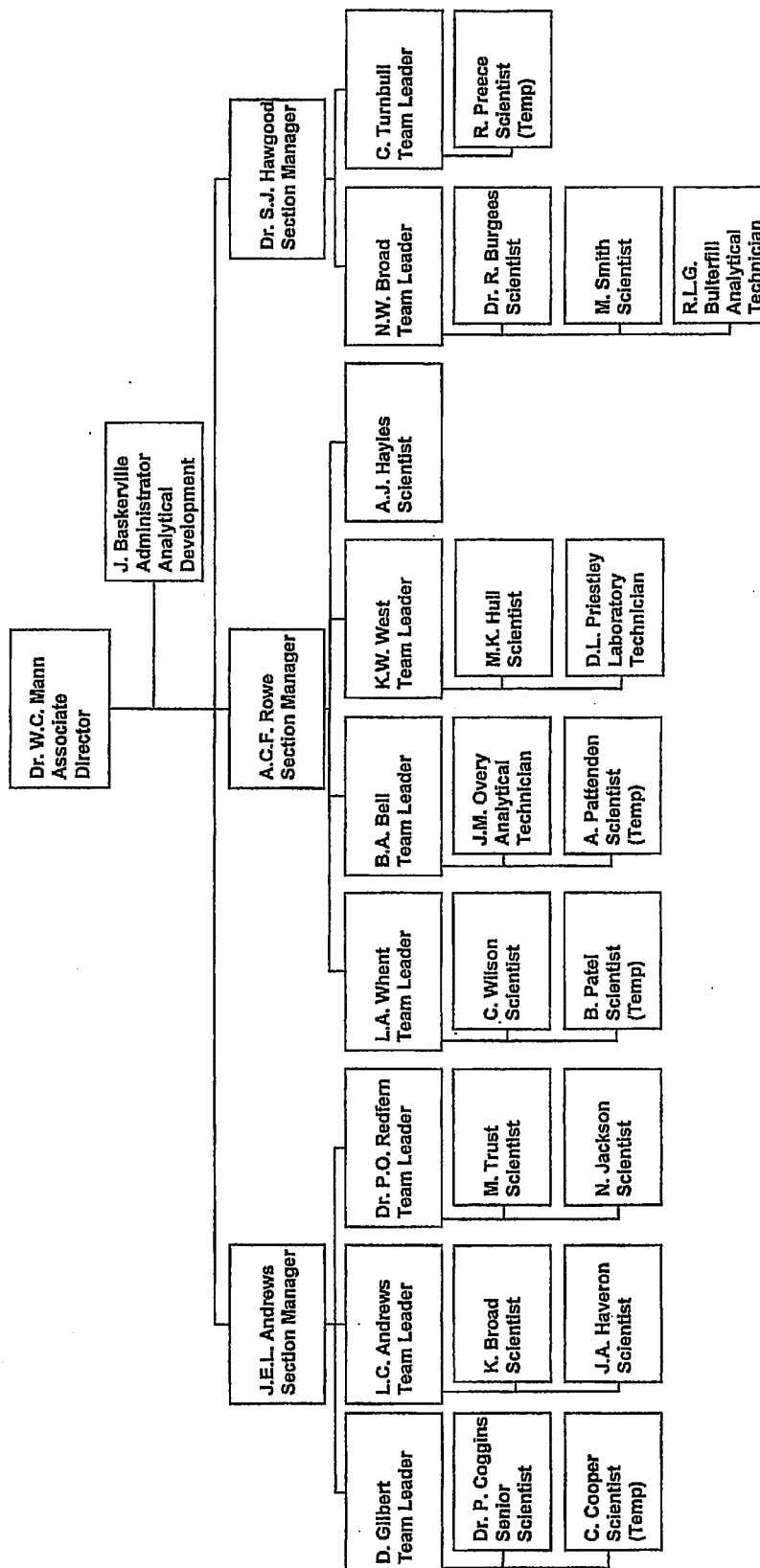
CH-228011-079jbr/cDC

IDC



CH-228011-079jb/rcDC

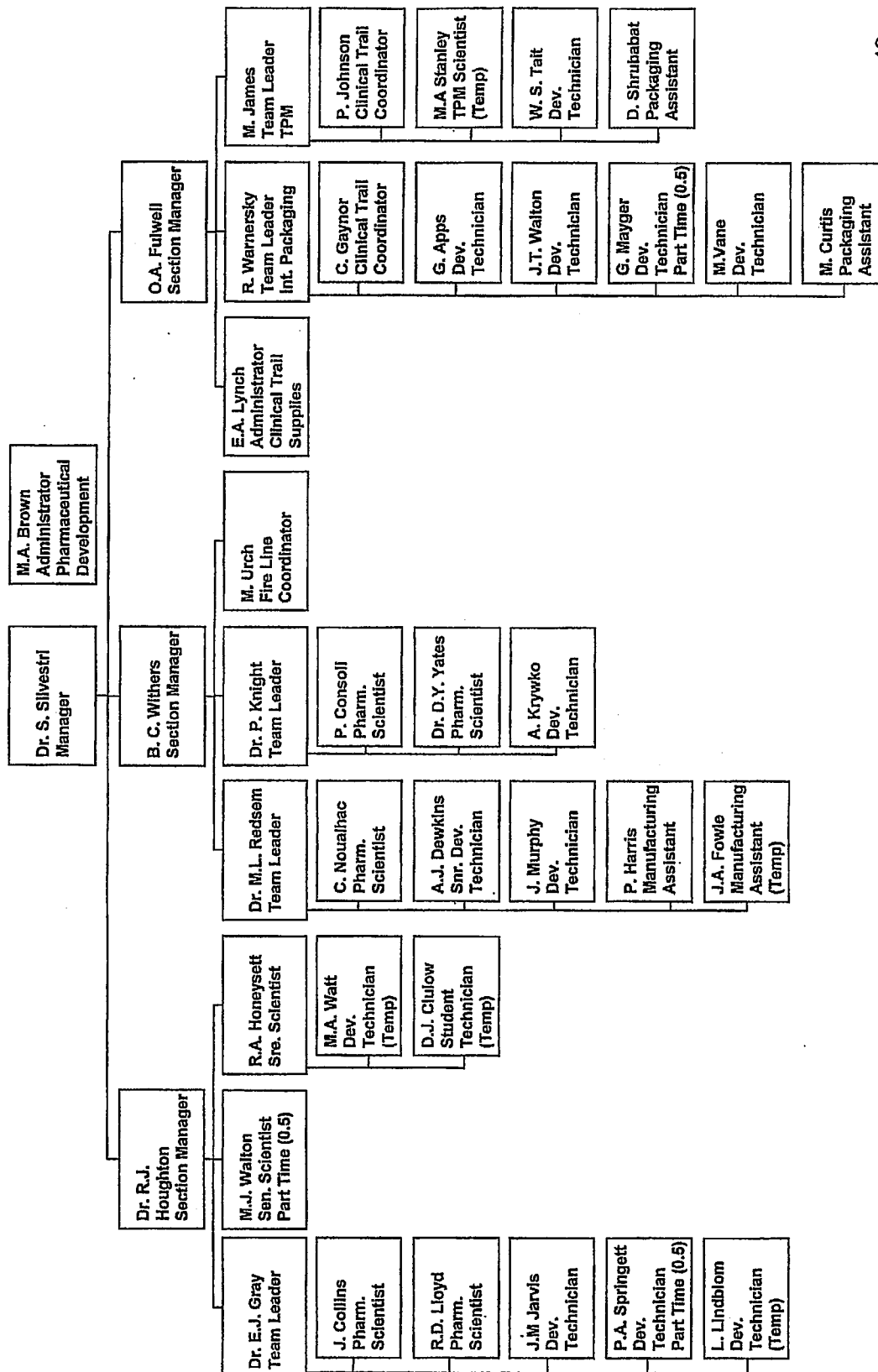
IDC ANALYTICAL DEVELOPMENT



Note: n = 30

CH-228011-079j/rcDC

IDC PHARMACEUTICAL DEVELOPMENT

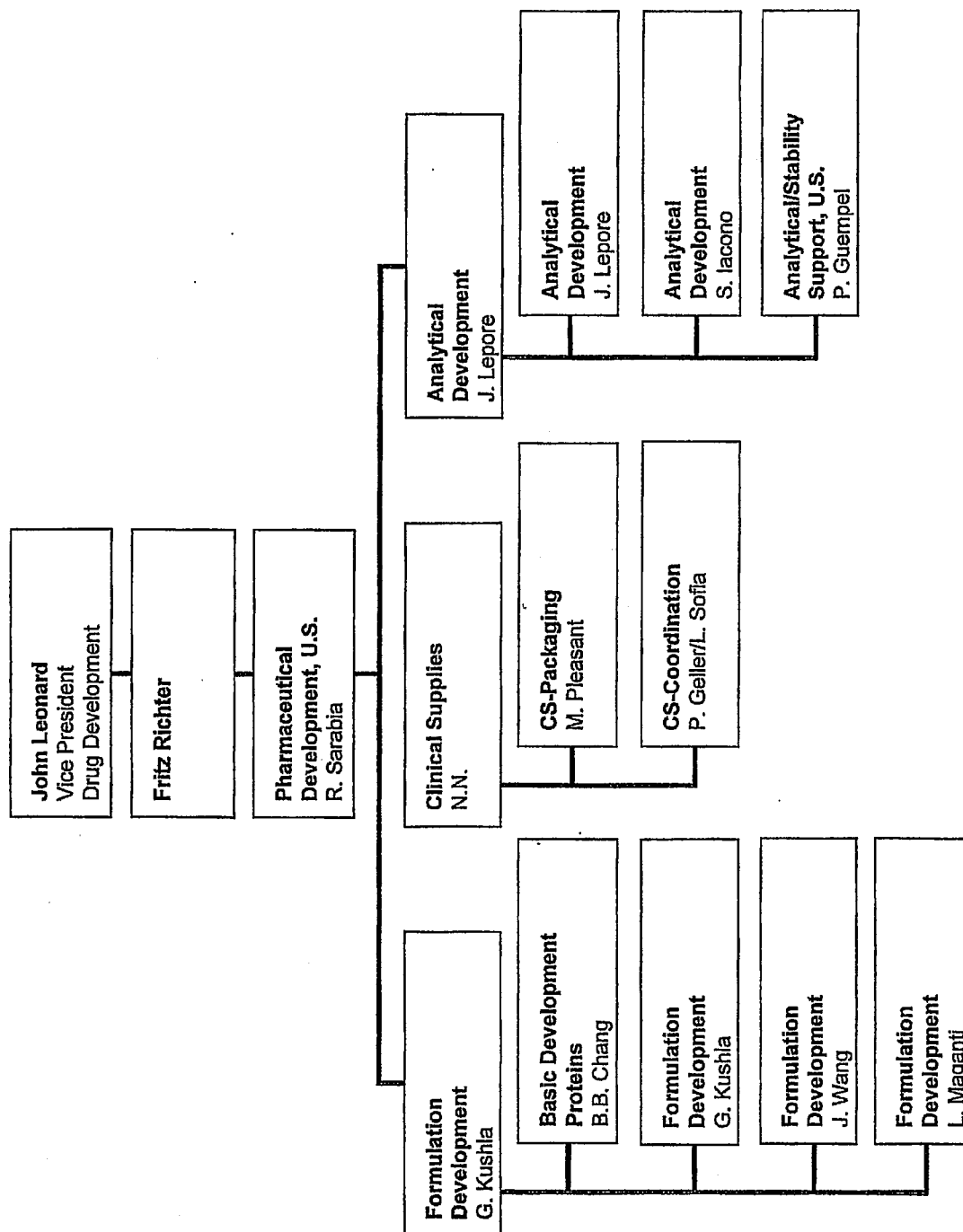


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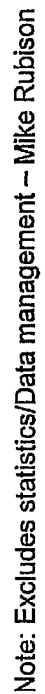
CH-228011-079jbr/dc

NEW JERSEY PHARMACEUTICAL DEVELOPMENT

JAN 2001



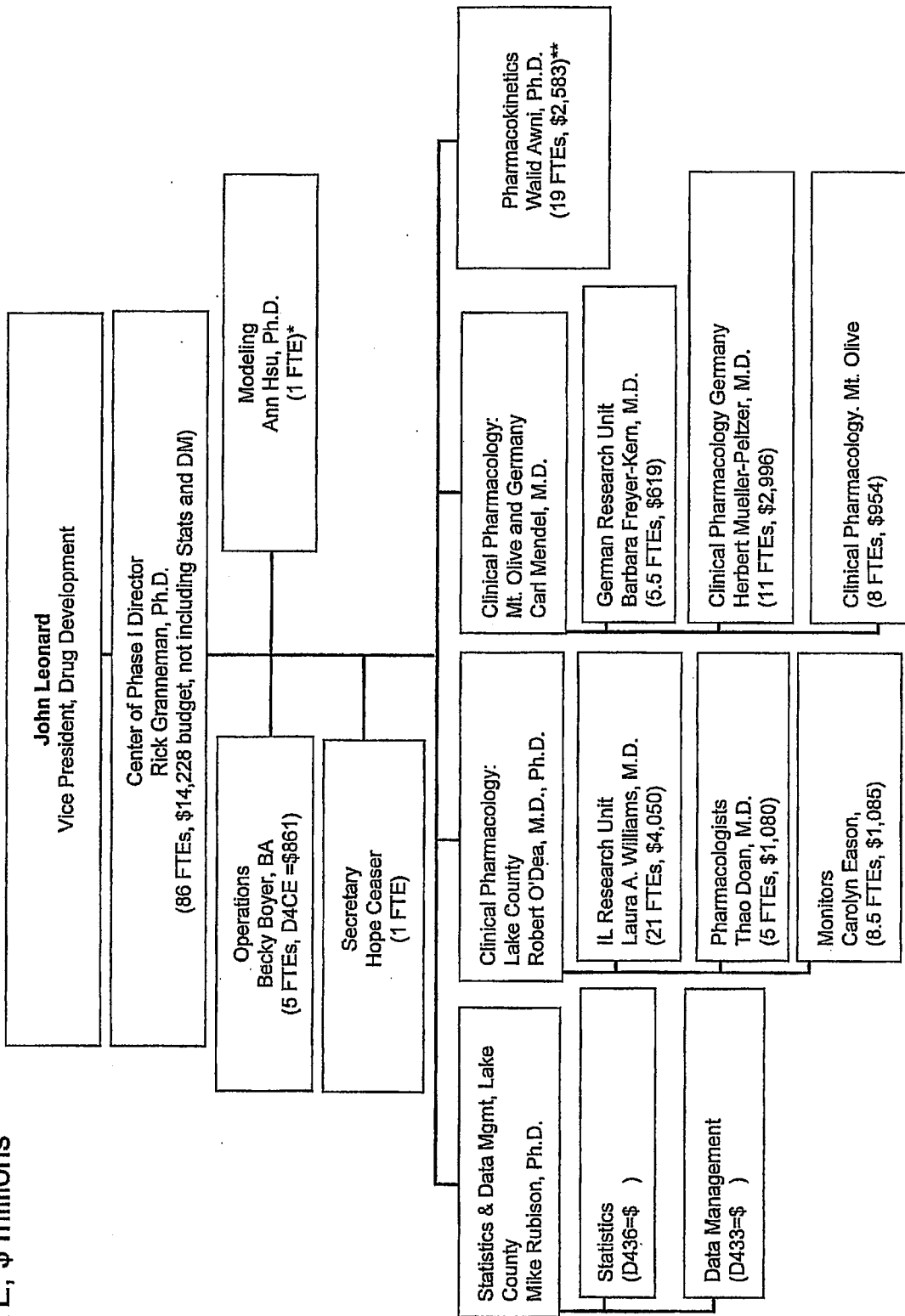
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CH-228011-079jbr/cdC

MARCH 2001**ABBOTT PHASE I ORGANIZATION**

FTE, \$ millions

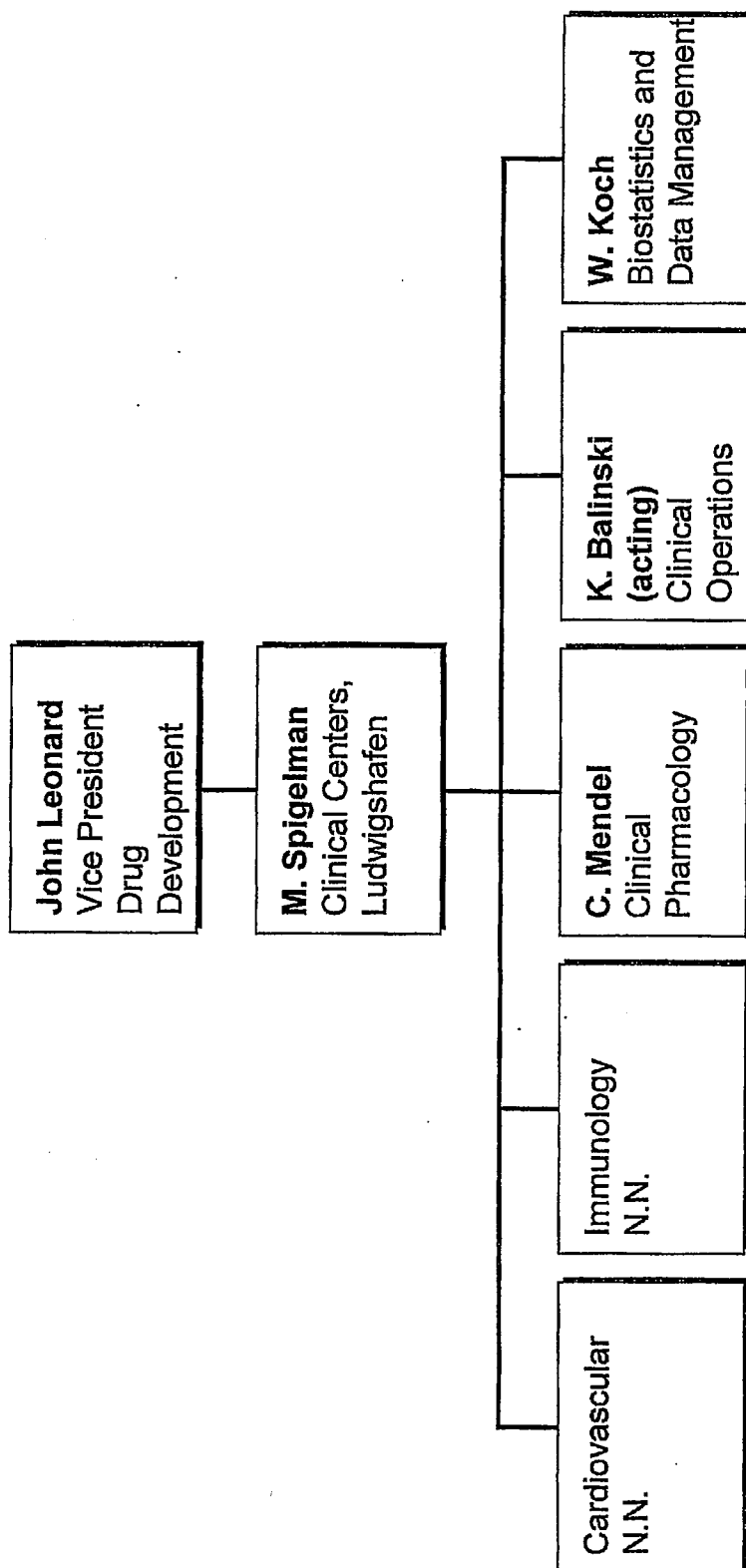


* Does not include Steve Mayer, M.D.

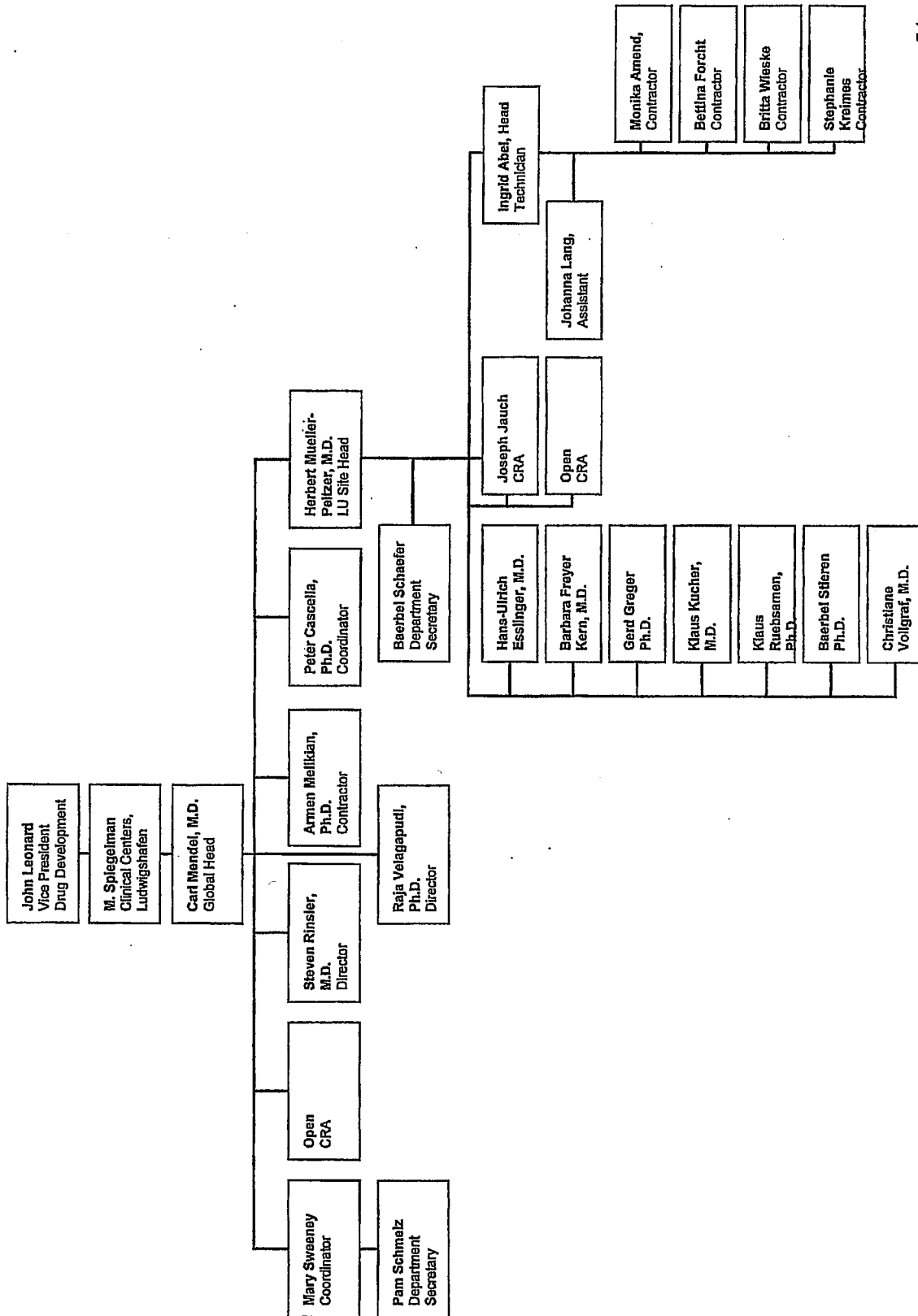
** Does not reflect new Ph.D. headcount from April Update

CH-228011-079jp/rcDC

X-KNOLL CLINICAL CENTERS



CH-228011-079jb/rcDC

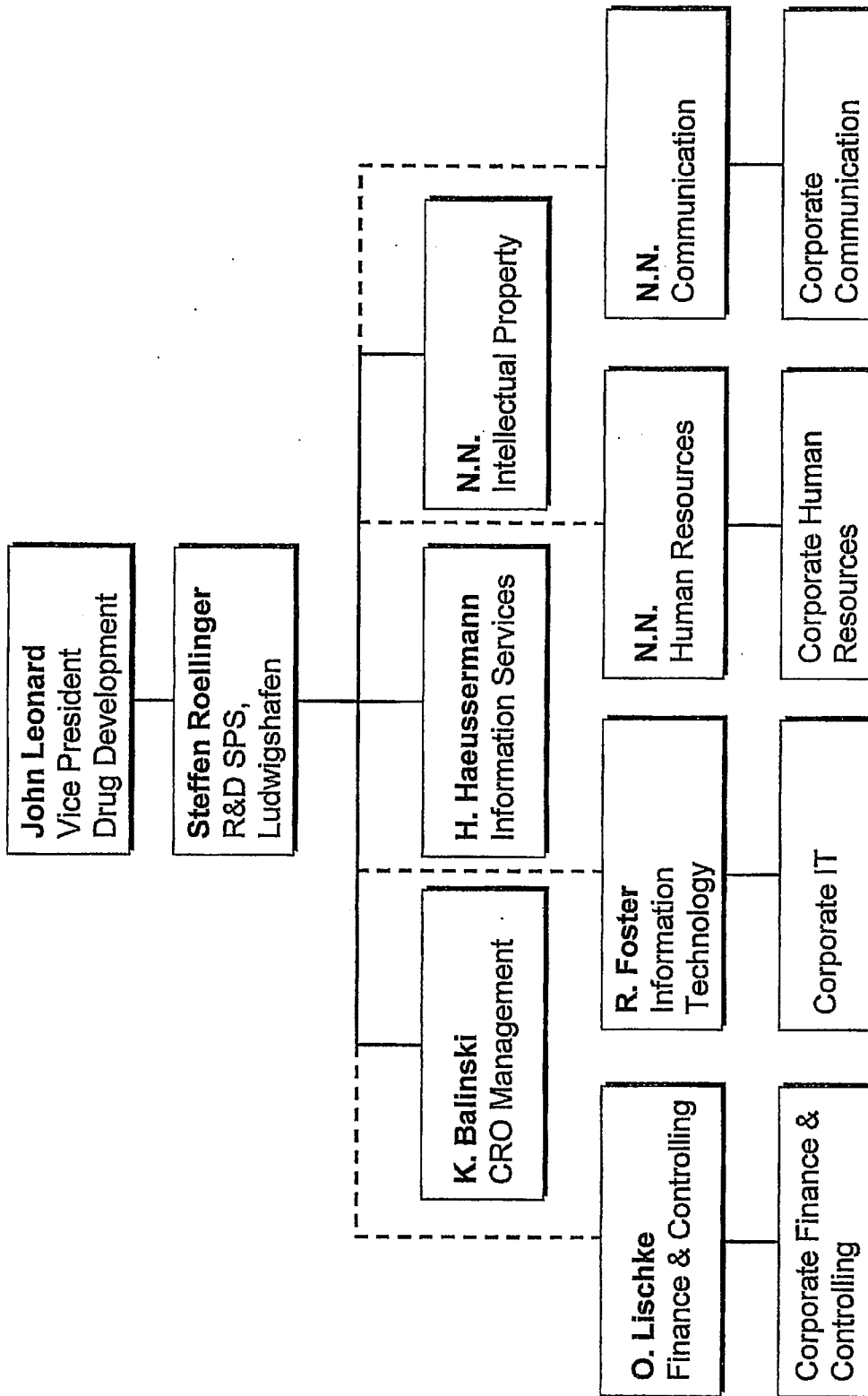
X-KNOLL CLINICAL PHARMACOLOGY (PHASE I)

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CH-228011-079jlr/raDC

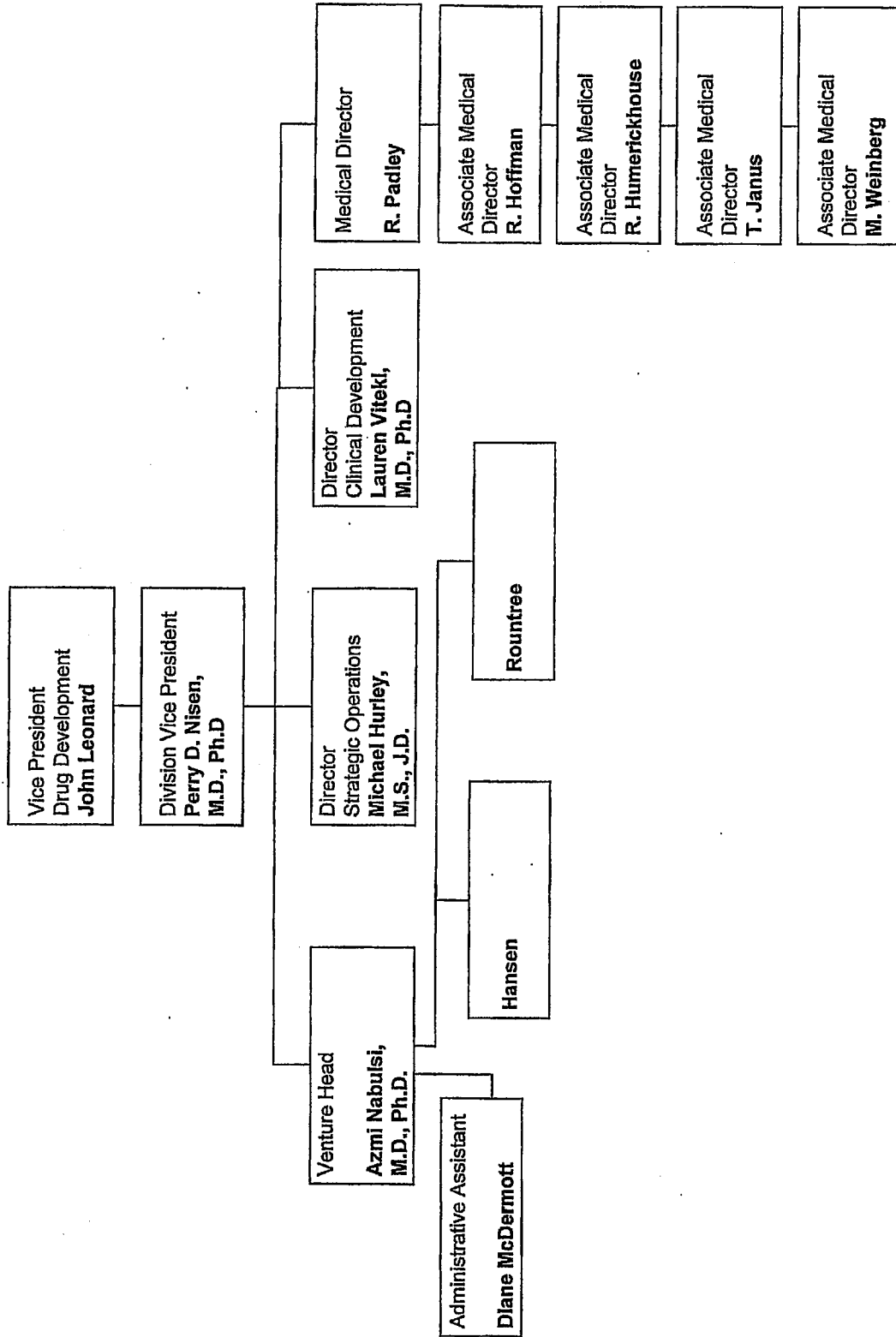
X-KNOLL R&D SYSTEMS, PROCESSES, AND SUPPORT

SEPTEMBER 2000



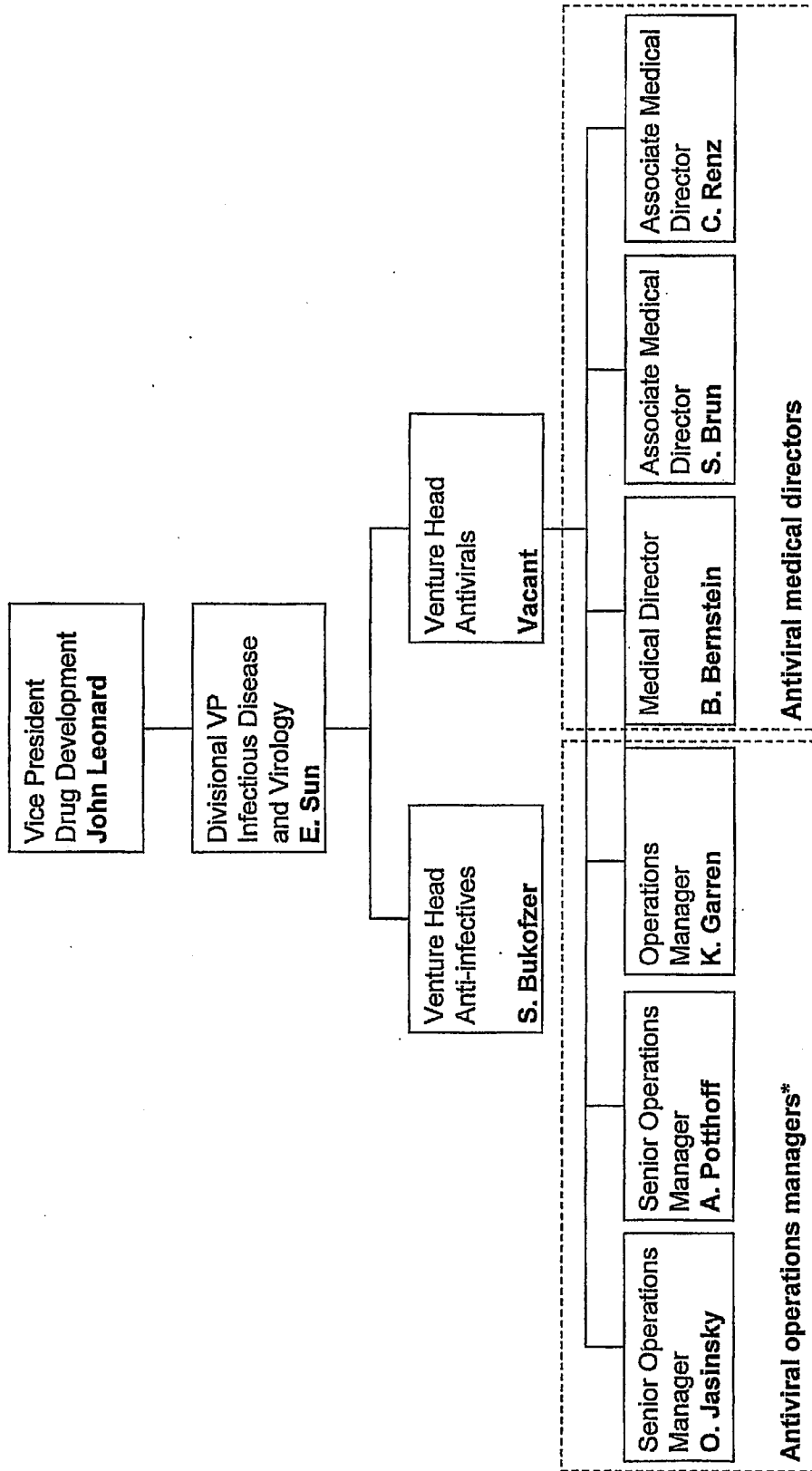
CH-228011-079jbr/cdC

GLOBAL PHARMACEUTICAL – ONCOLOGY VENTURE ORGANIZATION



CH-228011-079j/rcDC

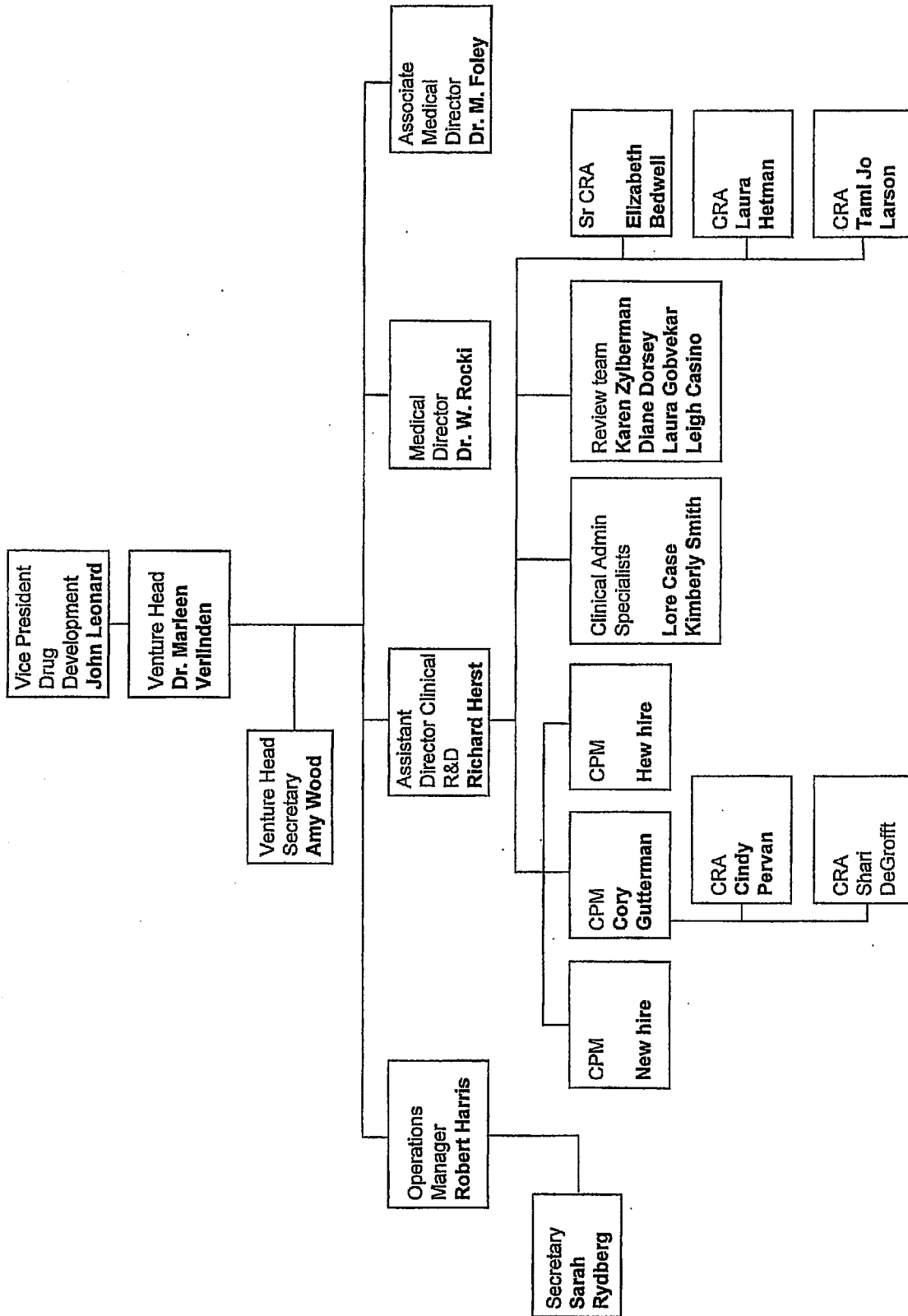
GLOBAL PHARMACEUTICAL – INFECTIOUS DISEASE AND VIROLOGY VENTURES ORGANIZATION



* Direct reports include Clinical Project Managers, Clinical Research Associates (CRAs), and Document Clerks

CH-228011-079jp/rdc

GLOBAL PHARMACEUTICALS – UROLOGY VENTURE ORGANIZATION

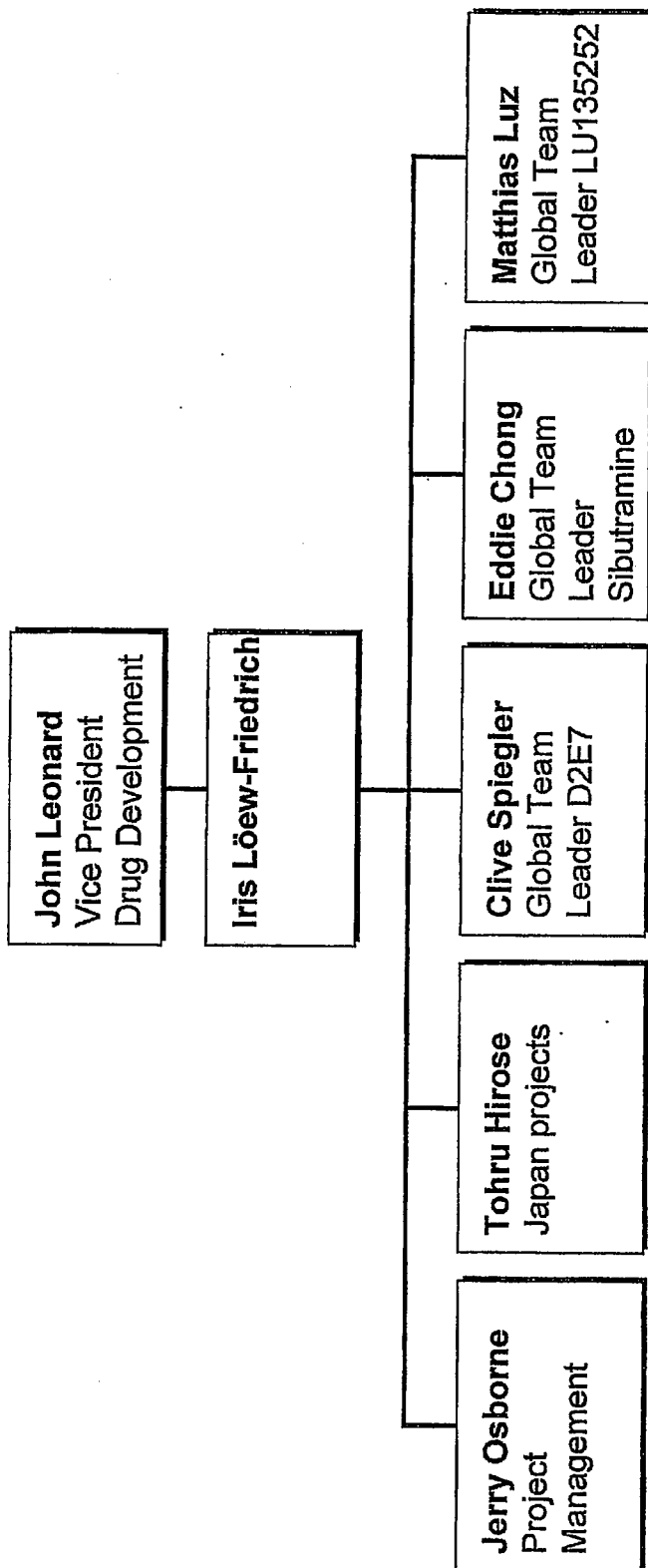


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CH-228011-079jb/rcdC

PRE-CLOSE

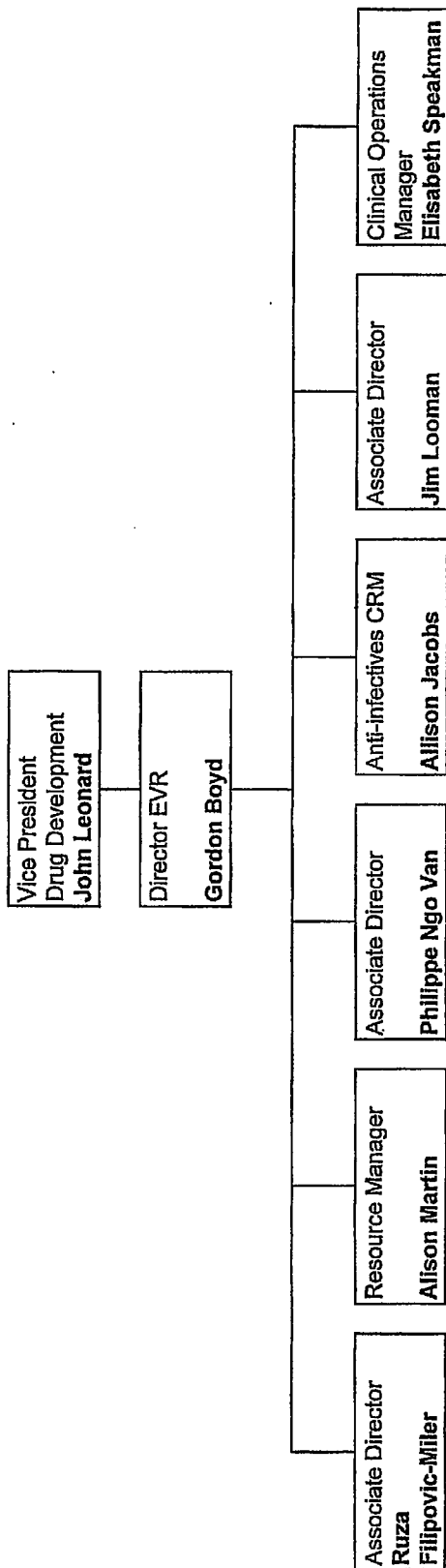
X-KNOLL – GLOBAL PROJECTS



Acting			
Lothar Daum	B. Rendenbach-Müller	Segard	Ancrod
Barry Gold	Rudi Scherhag	Dilaudid Oros	Clivarine

CH-228011-079jb/rcdc

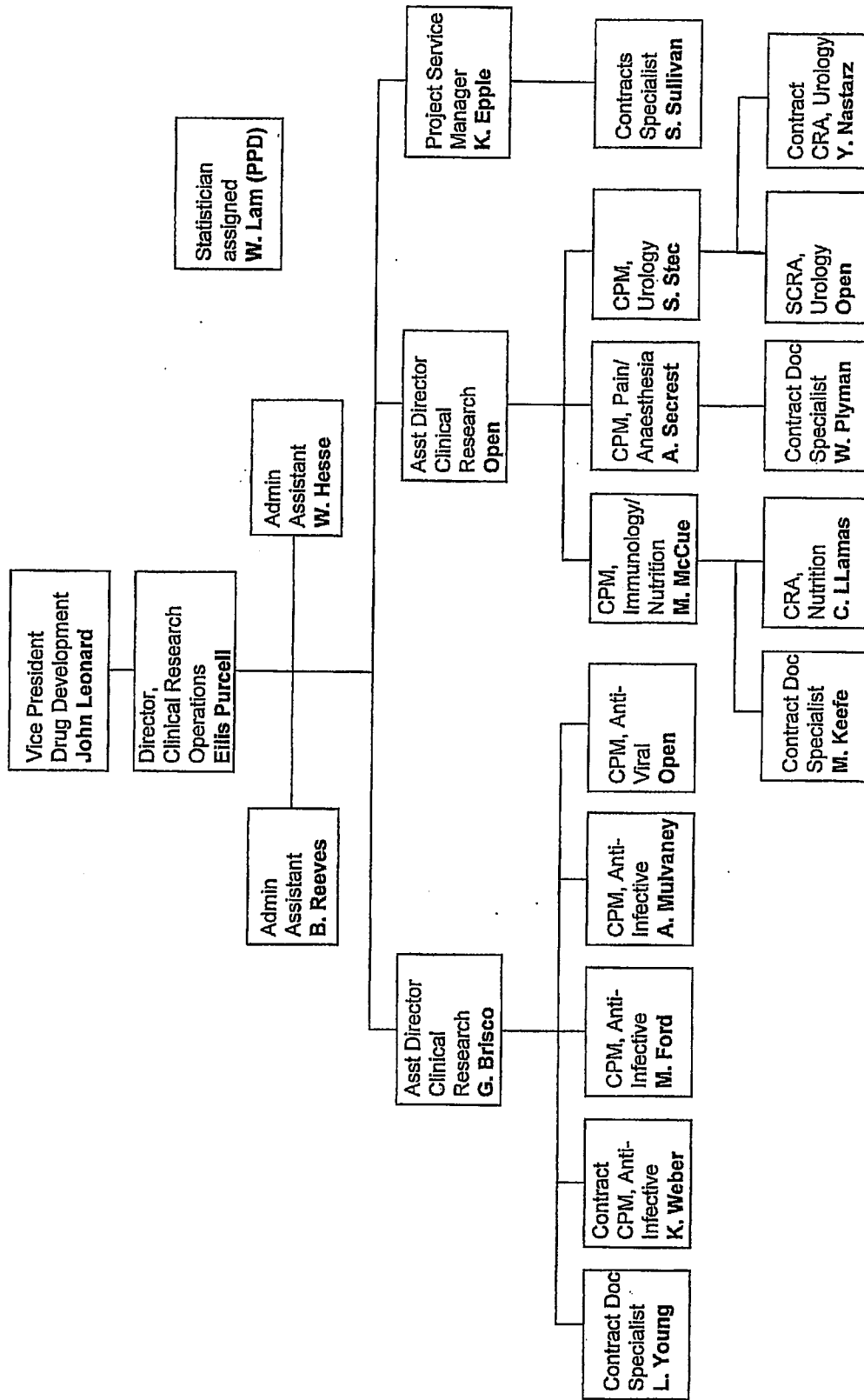
EUROPEAN VENTURE RESEARCH – ORGANIZATION



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CLINICAL OPERATIONS ORGANIZATION



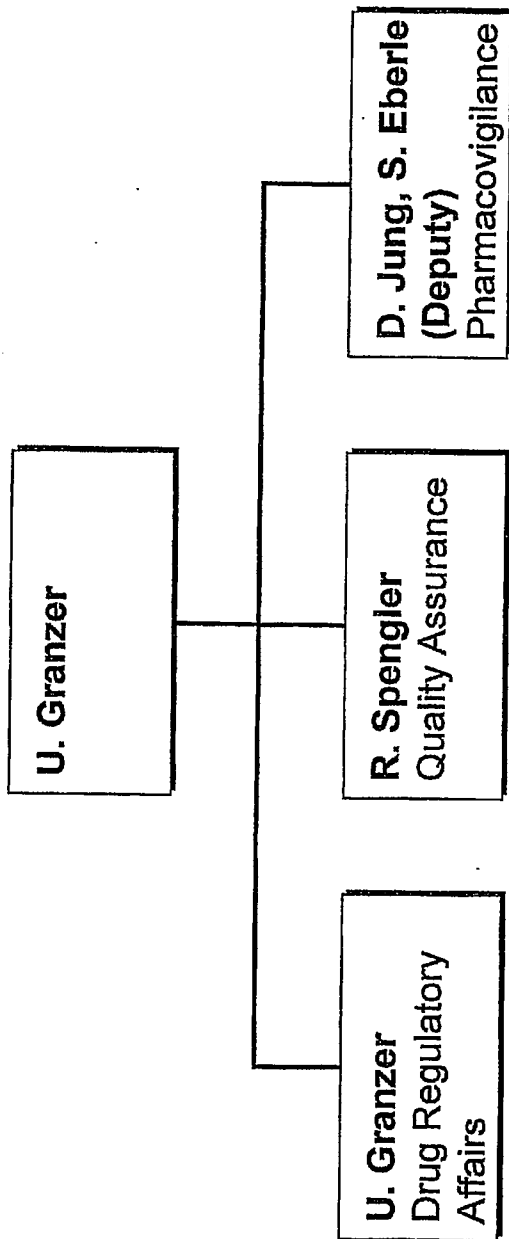
58

b6
b7C

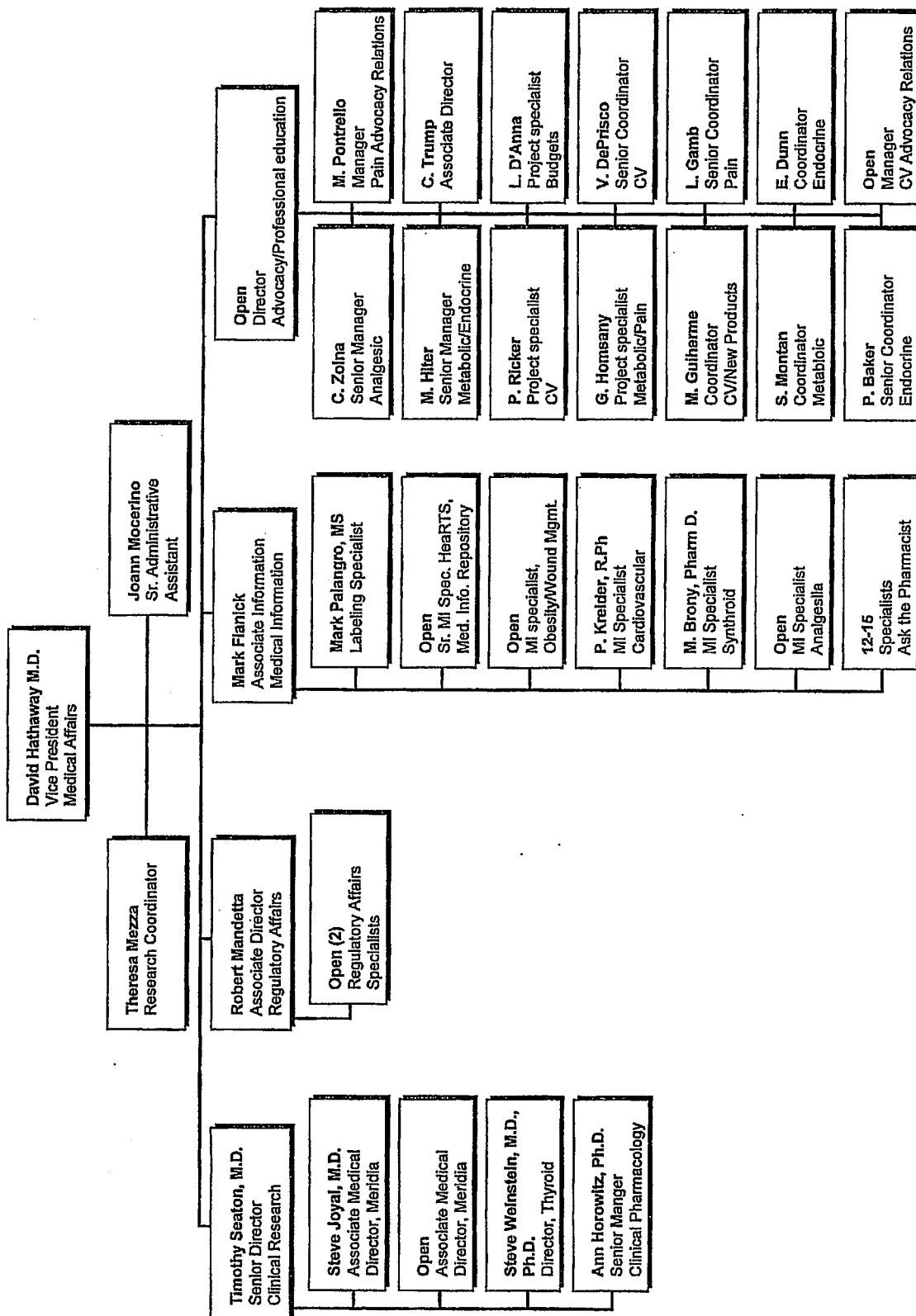
CH-228011-079jb/rdc

PRE-CLOSE

X-KNOLL REGULATORY CENTERS



CH-228011-079jb/rcDC

X-KNOLL – MEDICAL AFFAIRS

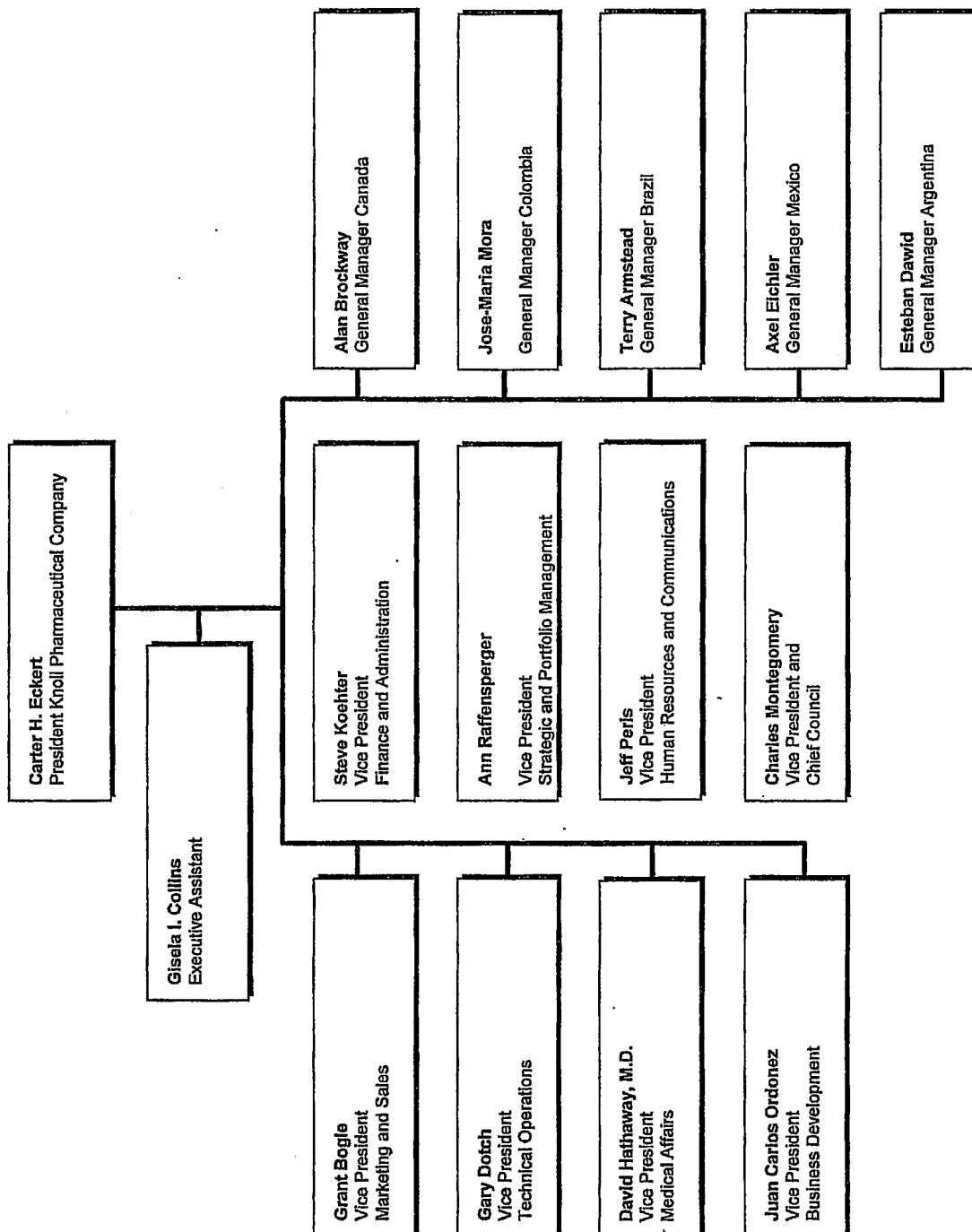
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X-KNOLL – AMERICAS PHARMACEUTICAL

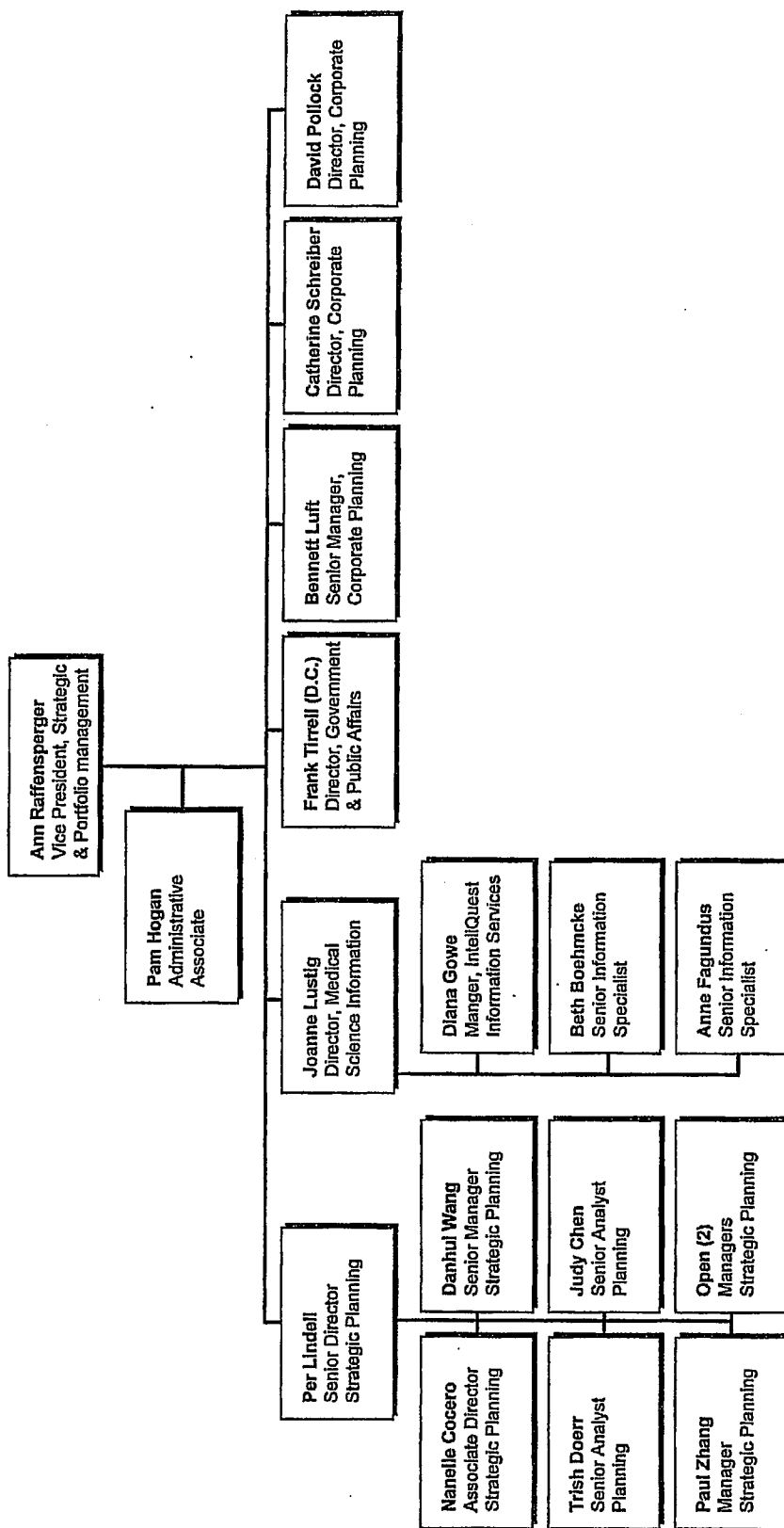


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MCK 00337

CH-228011-079j/rcDC

X-KNOLL – STRATEGIC AND PORTFOLIO MANAGEMENT

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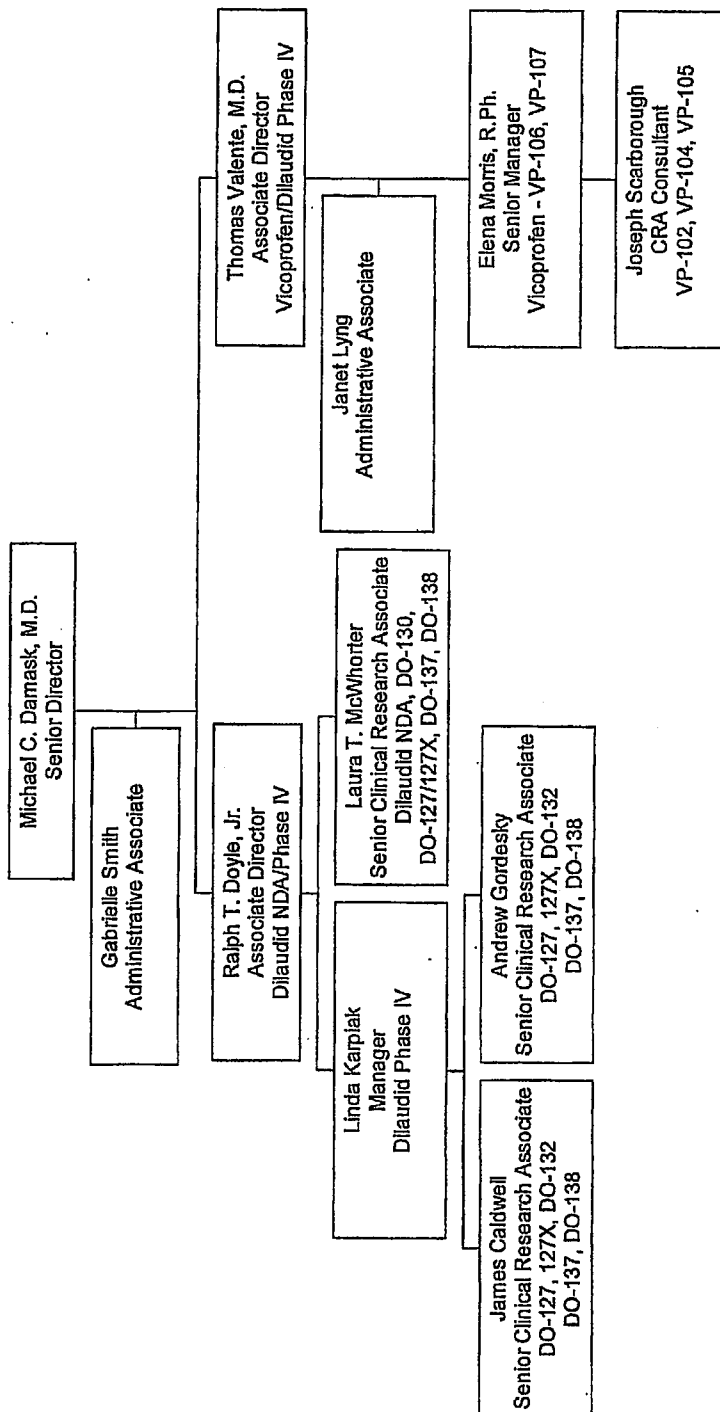
CONFIDENTIAL

MCK 00338

CH-228011-079jbr/dc

X-KNOLL US PHASE IV ACTIVITIES RESIDING IN R&D

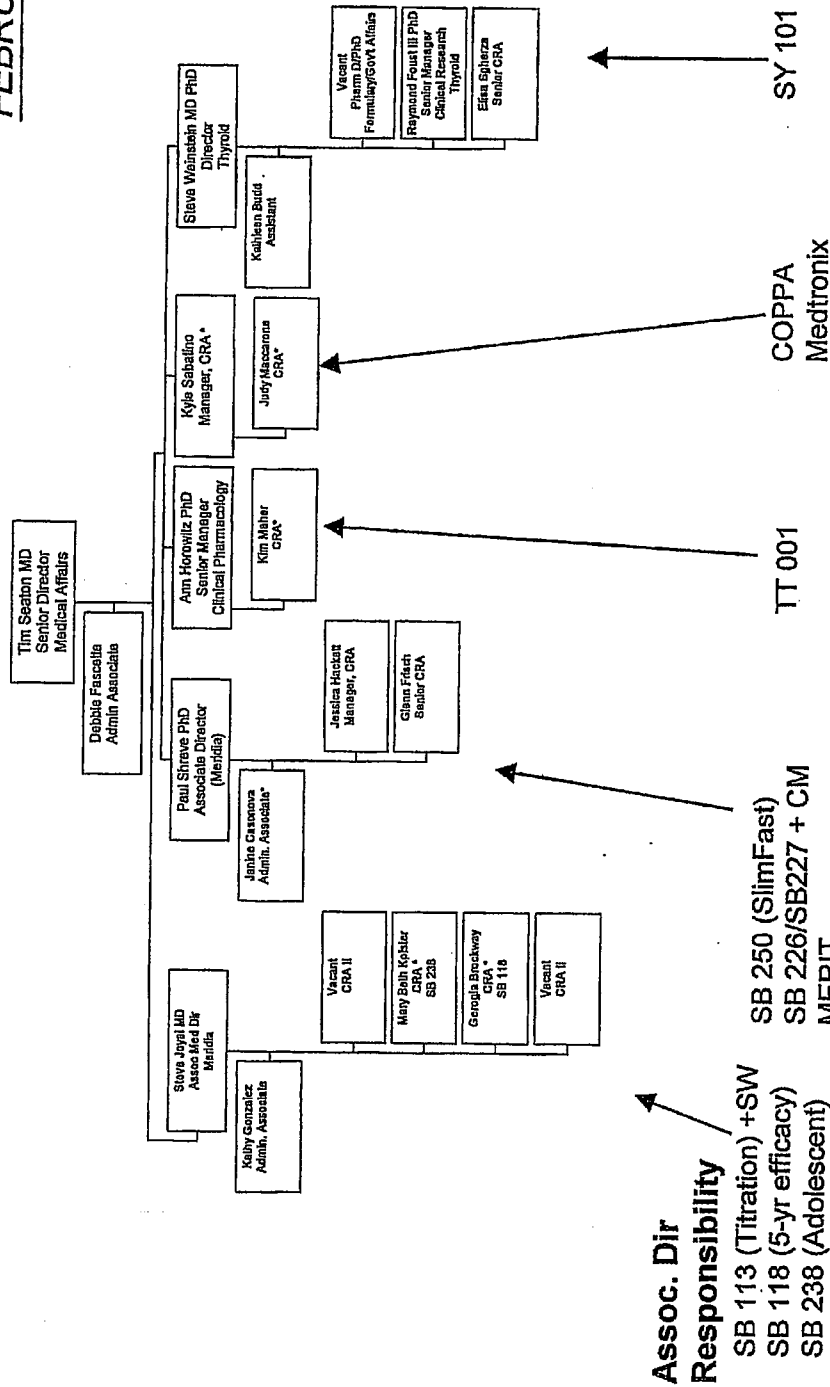
FEBRUARY 2001



CH-228011-079jb/rcDC

X-KNOLL US MEDICAL AFFAIRS ORGANIZATION CHART (WITH CONTRACTORS)

FEBRUARY 2001



D. Fascetta
SB 113
SB 237
TT 001

J. Casonova
SB 250
SB 226/227

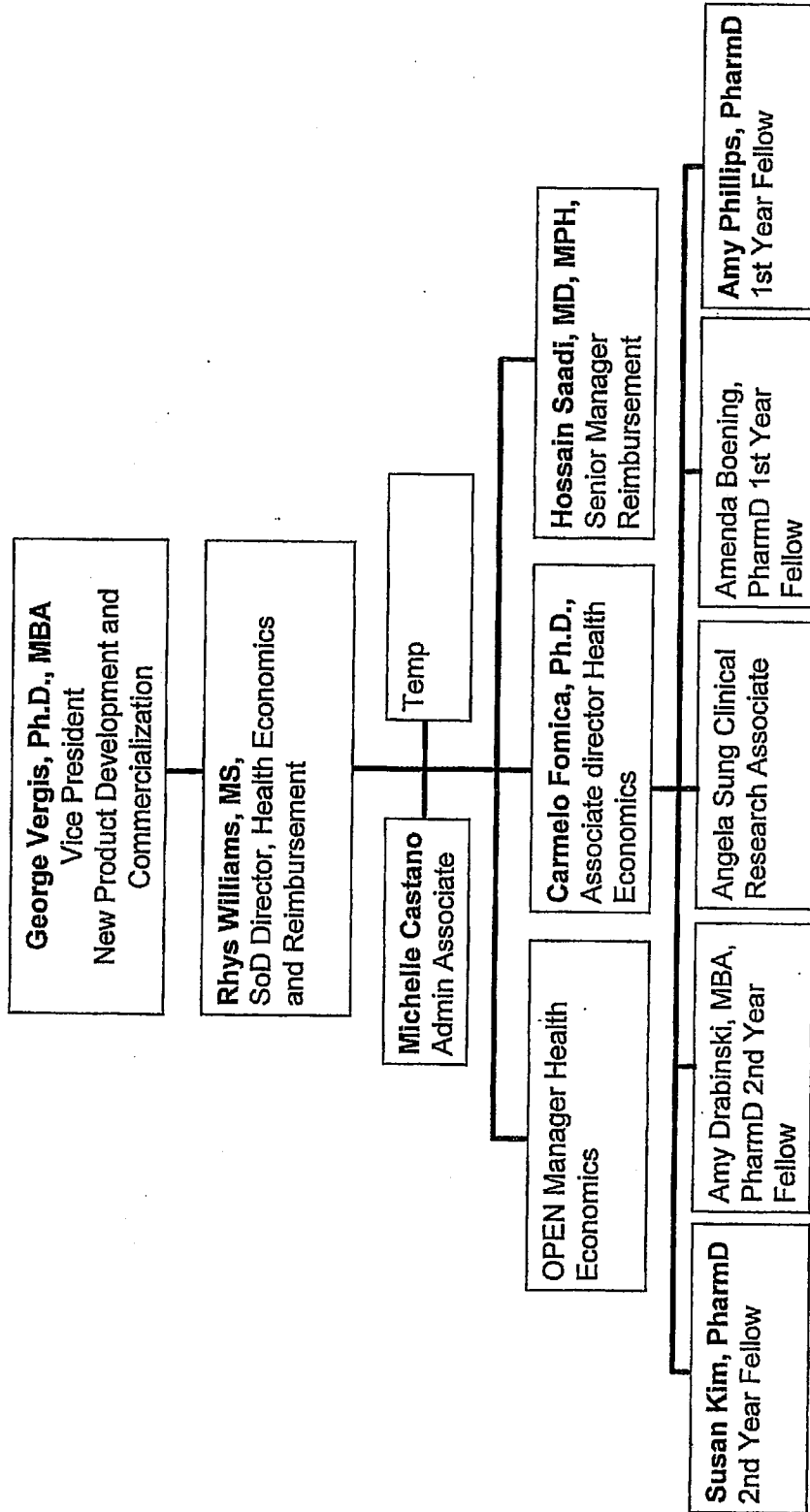
Admin Responsibility
K. Gonzalez
SB 118
SB 238
Descheduling

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CH-228011-079jbr/cdc

FEBRUARY 2001

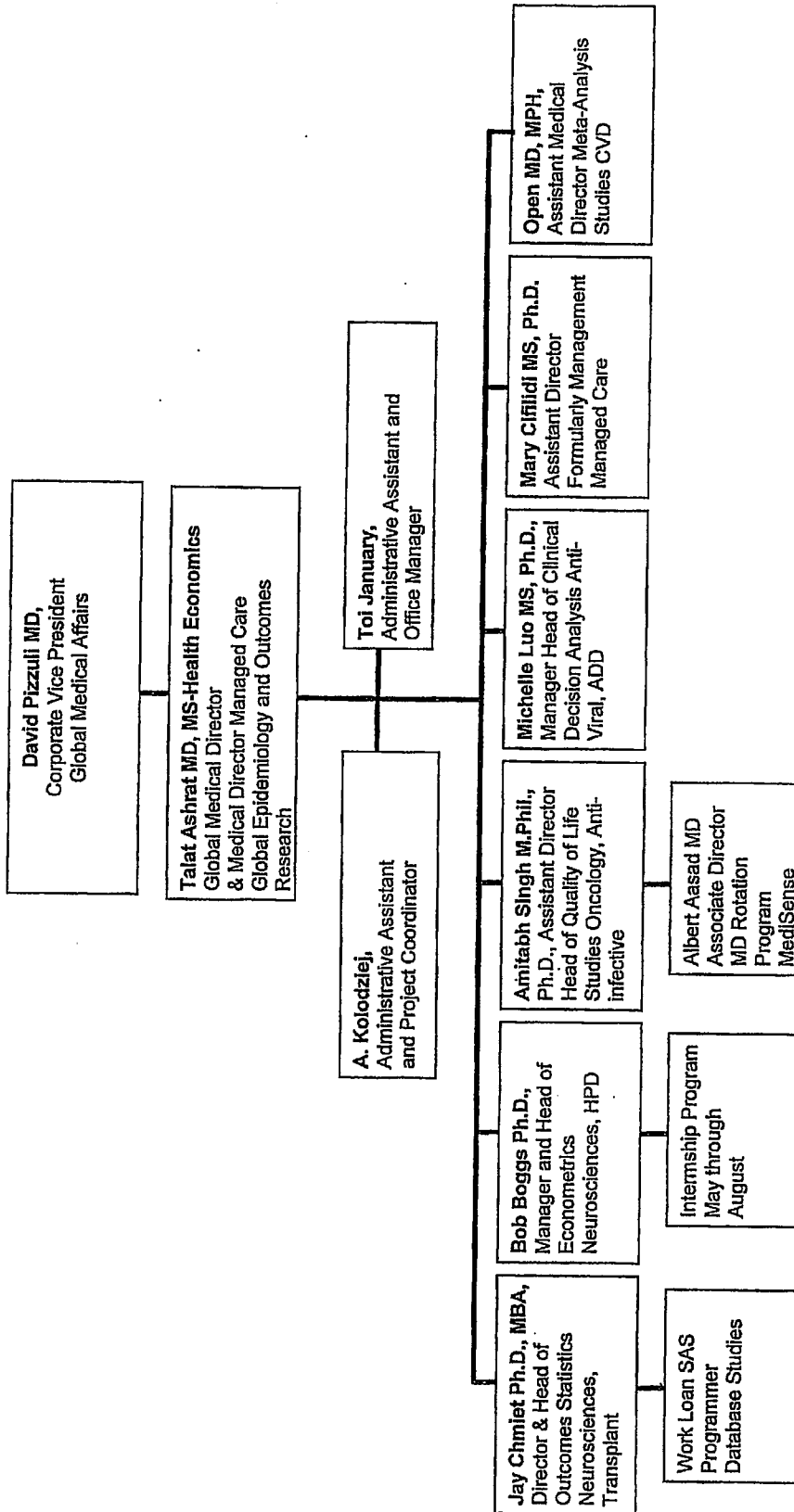
X-KNOLL HEALTH ECONOMICS AND REIMBURSEMENT



* Health economics and reimbursement currently maintains an overhead cost center within new product development and commercialization

CH-228011-079jbr/cdc

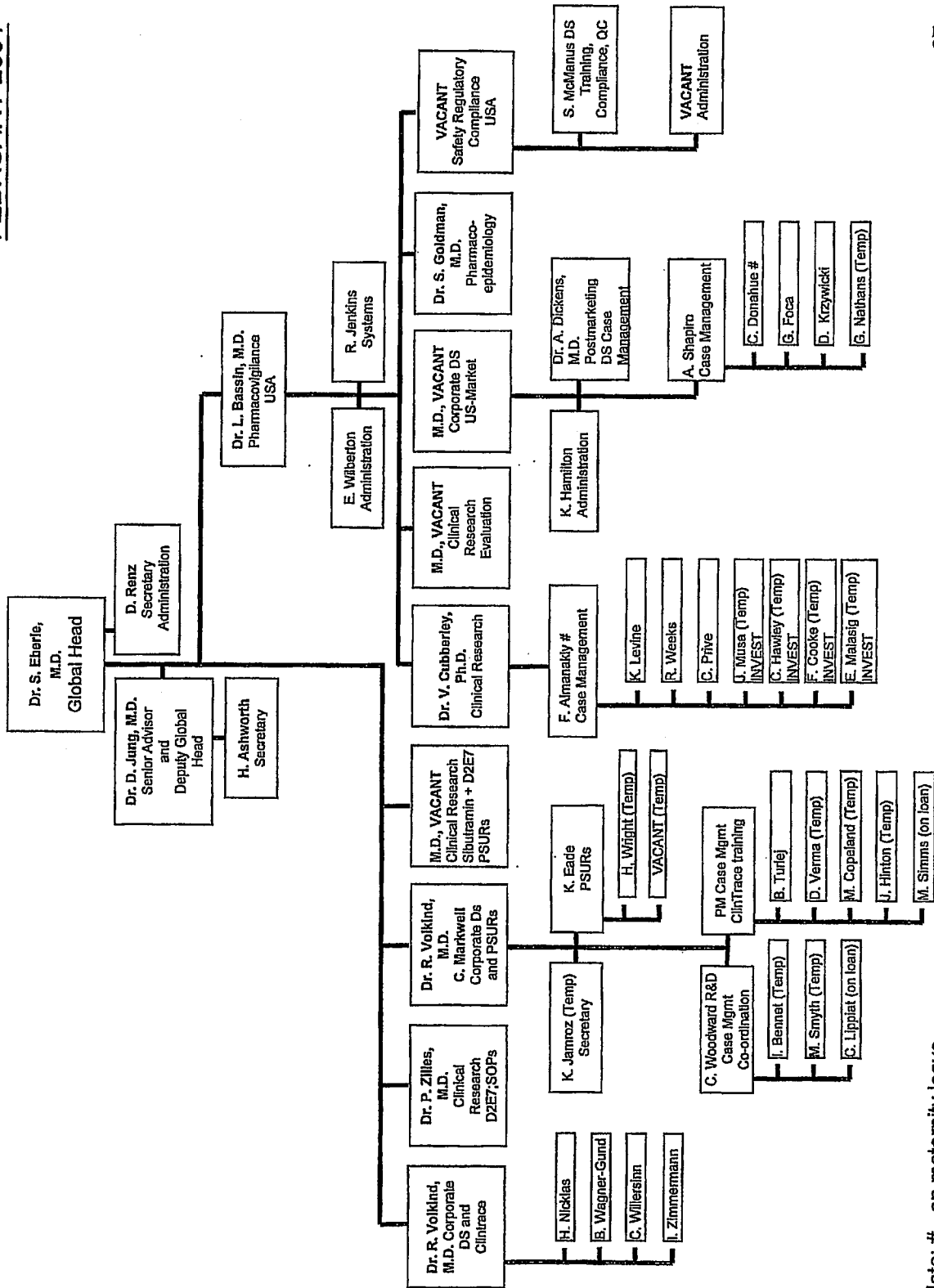
ABBOTT GLOBAL EPIDEMIOLOGY AND OUTCOMES RESEARCH



CH-228011-079jb/rcDC

FEBRUARY 2001

X-KNOLL GLOBAL PHARMACOVIGILANCE



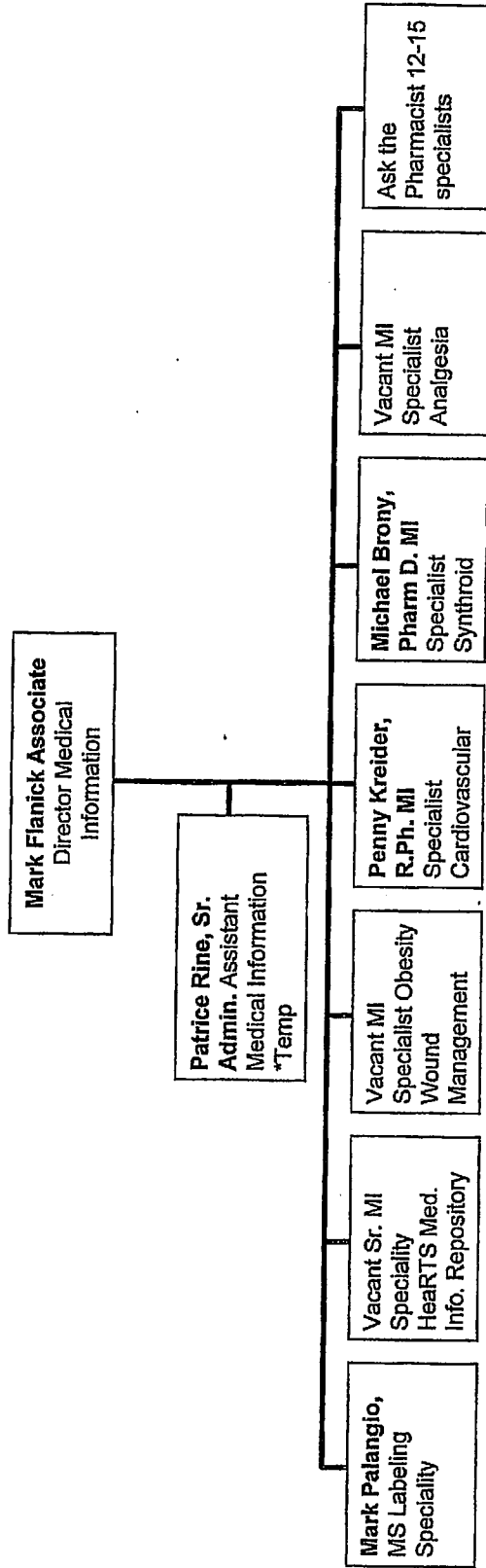
Note: # - on maternity leave

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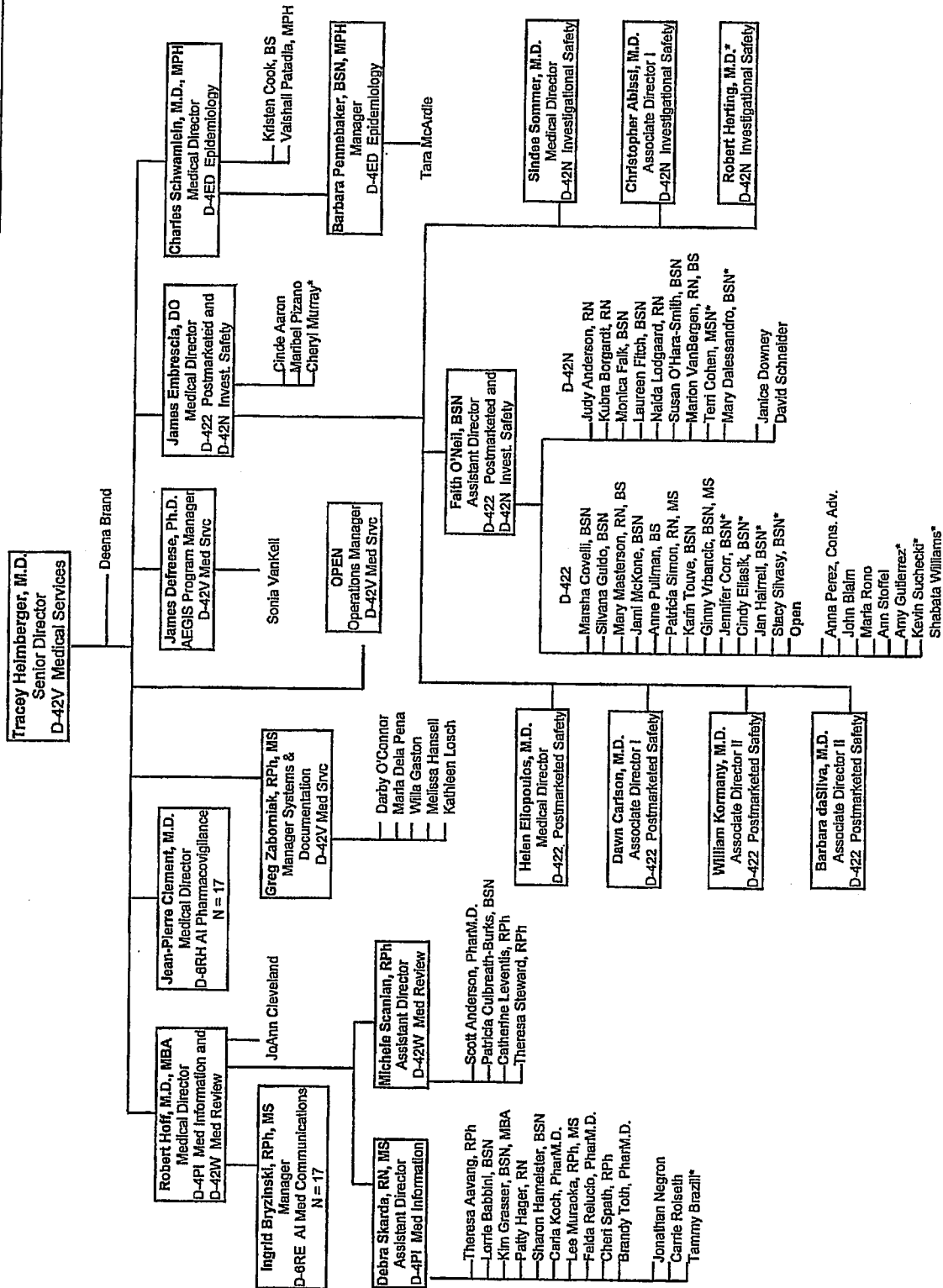
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FEBRUARY 2001

X-KNOLL MEDICAL INFORMATION – U.S.



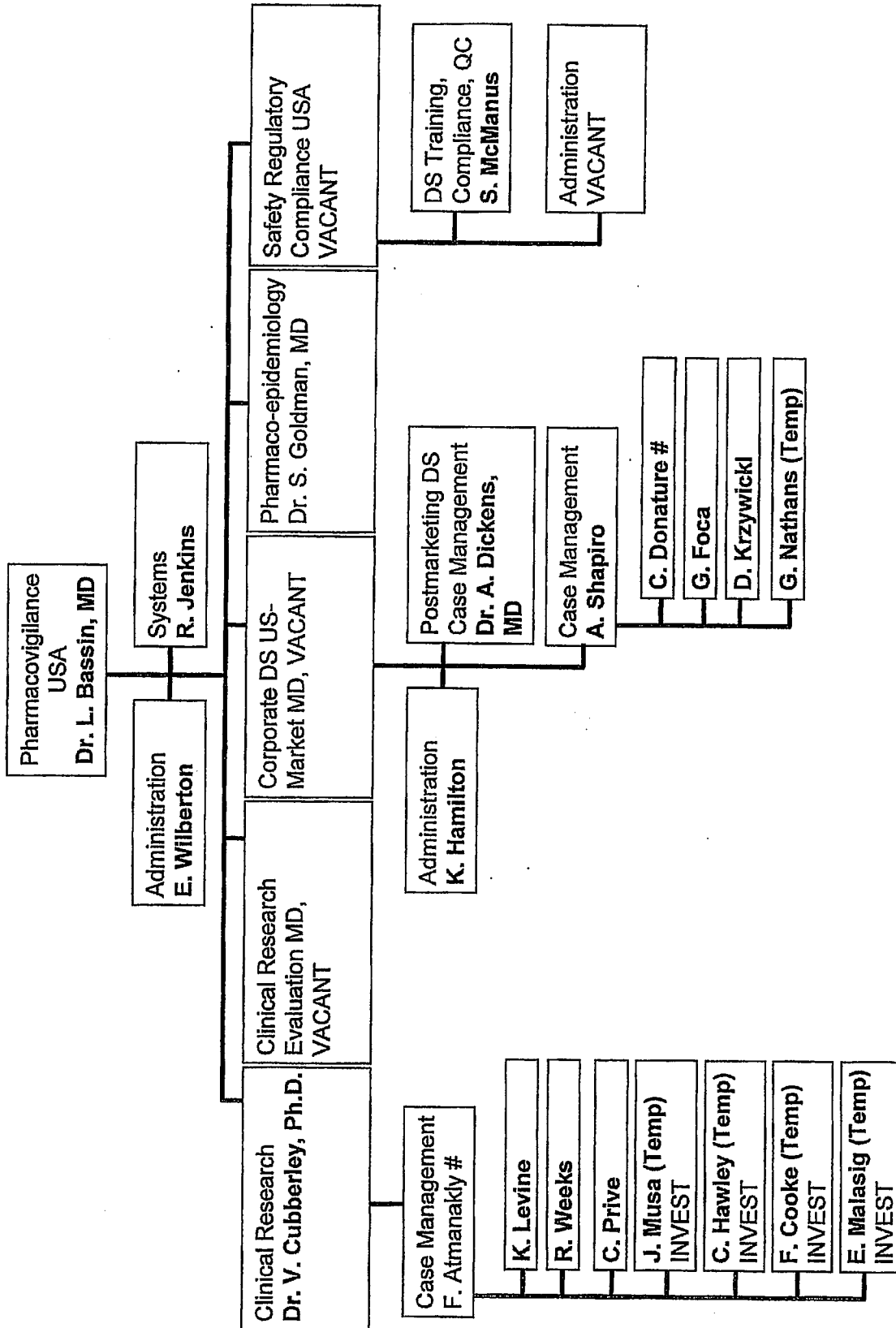
ABBOTT MEDICAL SERVICES



*** Contract personnel**

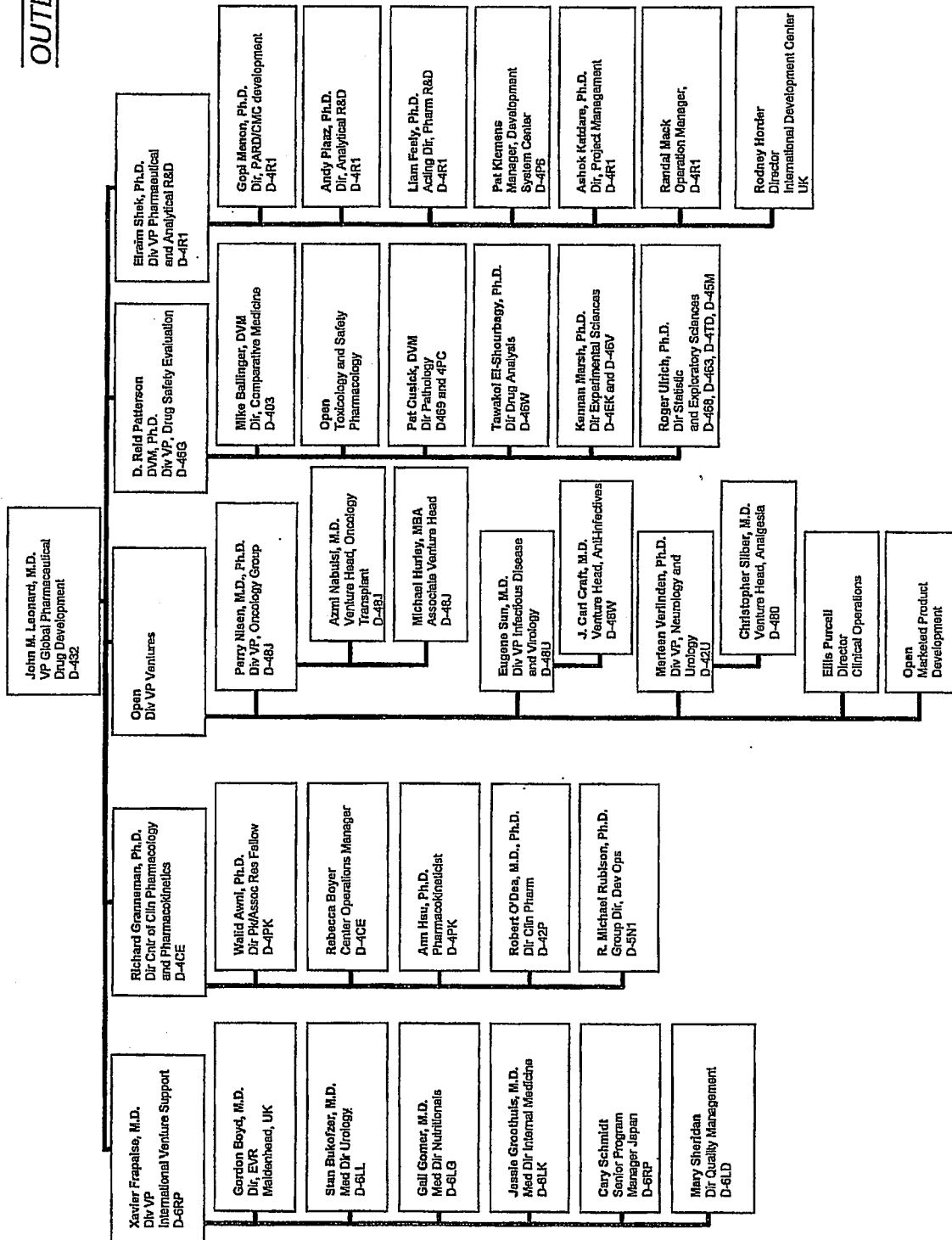
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CH-228011-079jb/rcDC

X-KNOLL PHARMACOVIGILANCE – U.S.**FEBRUARY 2001**

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CH-228011-079jbrdcg

GLOBAL PHARMACEUTICAL DRUG DEVELOPMENTDRAFTOUTDATED

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HOPFIELD Dep. Ex. 9 / PLs' FM

Elizabeth
Kowaluk/LAKE/PPRD/ABBO
TT
04/10/2001 04:25 PM

To Keith F Hendricks/LAKE/AI/ABBOTT@ABBOTT, Steve C
Kuemmerle/LAKE/PPRD/ABBOTT@ABBOTT
cc
bcc
Subject Pharma Strategy Retreat on May 2-4

Keith, Steve

Here is the latest from Marleen on the therapeutic area strategy work. As we discussed earlier today, I will continue to work with Marleen and Jim to assist with the R&D inputs to this template, to the extent that it does not interfere with our portfolio work (naturally that comes first). I'd especially like to keep abreast of the Pain project, so that I can pick up the ABT-594 analysis once they are done with this exercise.

Also note the first attachment - this seems to be the final word on therapeutic area designations, and should be helpful for the Portfolio analysis.

Liz

Forwarded by Elizabeth Kowaluk/LAKE/PPRD/ABBOTT on 04/10/2001 04:21 PM

Marleen H Verlinden
04/10/2001 03:19 PM

To: James Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Bruce McCarthy/LAKE/PPRD/ABBOTT@ABBOTT, Charles McLeskey/HPD/Abbott@Exchange@ABBOTT, John Heden/HPD/Abbott@Exchange, James T Doran/LAKE/HPD/ABBOTT@ABBOTT, Laura Robinson/LAKE/AI/ABBOTT@ABBOTT, Ralf Krauthelmer/KNOLL-AG/BASF@KNOLL-AG, Mike Coghlan/LAKE/PPRD/ABBOTT@ABBOTT, Jorge D Brioni/LAKE/PPRD/ABBOTT@ABBOTT, Damien Springuel/LAKE/AI/ABBOTT@ABBOTT, Elizabeth Kowaluk/LAKE/PPRD/ABBOTT@ABBOTT, Margaret A Foley/LAKE/PPRD/ABBOTT@ABBOTT, Colin Durnin/KNOLL-UK/BASF@KNOLL-UK, Connie Faltynek/LAKE/PPRD/ABBOTT@ABBOTT, Paul L Bems/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Stan Bukofzer/LAKE/PPRD/ABBOTT@ABBOTT, urodoc@dia.pipex.com @ internet, Robert S Altman/LAKE/PPD/ABBOTT@ABBOTT, Paul L Bems/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Marilou Reed/LAKE/PPRD/ABBOTT@ABBOTT, Nigel Livesey/LAKE/AI/ABBOTT@ABBOTT, John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Johan M Baeck/LAKE/AI/ABBOTT@ABBOTT
cc: John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Dan W Norbeck/LAKE/PPRD/ABBOTT@ABBOTT
Subject: Pharma Strategy Retreat on May 2-4

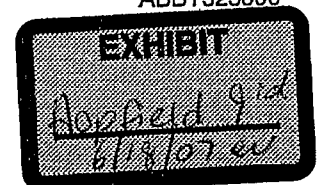
Please find herewith Jeff Leiden's templates for his off site retreat

The direction we receive herewith is quite different from the brief we had received so far. This will necessitate a reorganization of the teams and task assignments. Please look at the templates below.

In view of the extremely short period of time left to do this exercise, I believe it is unrealistic to assume that we can do all of this work collectively, i.e. in the course of "full-team meetings". I suggest for John, Ralf, Paul (analgesia), and for Johan and Bob (Urology) to collect the commercial info via separate meetings of the commercial folks, and for our core team as it existed to date to focus on the medical/clinical/discovery/technical development issues in the templates. The information gathering and preparation of our drafts, each in our respective areas of expertise, will probably take most of the two coming weeks. For the core team, please let's keep our scheduled meetings. I suggest that we clear our calendars completely in the week preceding April 30 and organize a few days

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for medical/discovery and commercial to all come together and reconcile the marketing and medical/science templates, if needed, and finalize the presentations. Given the horrendous size of the exercise "in virtual time", do you agree that this approach make sense?

I would like to request that we keep our minds open for new ("scientific franchise") opportunities, -as we were initially briefed-, even if they do not fit in the current franchises, such as for instance a much broader definition of the visceral pain opportunity, spanning over a number of areas that are existing or potentially new for Abbott (e.g. in urology, gastroenterology, analgesia). Let's keep in mind that the brief we got verbally was to not get boxed -in our thinking, to think about this innovatively, and identify where medical and scientific opportunities may exist now which could bring innovative compounds to market 10 years from now and make us an innovator with a majority of breakthrough, as opposed to follower, compounds. This may require some flexibility in our thinking about the future by venturing outside the currently commercially pre-defined Abbott areas.

John (Leonard), Dan, please advise us if this part of the brief no longer is valid.

Marleen

Forwarded by Marleen H Verlinden/LAKE/PPRD/ABBOTT on 04/10/2001 02:24 PM

From: Jeff M Leiden on 04/10/2001 12:27 PM

Sent by: Kathy A Hundley

To: Bruce McNutt/HPD/Abbott@Exchange, Charles McLeskey/HPD/Abbott@Exchange@ABBOTT, David Ostrow/HPD/Abbott@Exchange@ABBOTT, Eugene X Sun/LAKE/PPRD/ABBOTT@ABBOTT, Frank W Zhou/LAKE/AI/ABBOTT@ABBOTT, Fritz-Frieder Frickel/KNOLL-AG/BASF@KNOLL-AG, George Maliekal/HPD/Abbott@Exchange@ABBOTT, Heather L Mason/LAKE/PPD/ABBOTT@ABBOTT, Iris Loew-Friedrich/KNOLL-AG/BASF@KNOLL-AG, James Sullivan/LAKE/PPRD/ABBOTT@ABBOTT, Jerald J Wenker/LAKE/PPD/ABBOTT@ABBOTT, Johan M Baeck/LAKE/AI/ABBOTT@ABBOTT, John Arnot/LAKE/AI/ABBOTT@ABBOTT, John Heden/HPD/Abbott@Exchange, John Toner/HPD/Abbott@Exchange, Lauren V Vitek/LAKE/HPD/ABBOTT@ABBOTT, Mark J Webster/LAKE/PPD/ABBOTT@ABBOTT, Marleen H Verlinden/LAKE/PPRD/ABBOTT@ABBOTT, Mary Szela/HPD/Abbott@Exchange@ABBOTT, Michael Kirchengast/KNOLL-AG/BASF@KNOLL-AG, Loreen Mershimer/HPD/Abbott@Exchange@ABBOTT, Paul L Berns/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP, Perry D Nilsen/LAKE/PPRD/ABBOTT@ABBOTT, Ralf Krautheimer/KNOLL-AG/BASF@KNOLL-AG, Richard J Marasco/LAKE/PPD/ABBOTT@ABBOTT, Robert I Kamen/NV/WORCESTER/BASF-CORP/BASF@BASF-CORP, Robert S Altman/LAKE/PPD/ABBOTT@ABBOTT, Ronald K Lloyd/LAKE/AI/ABBOTT@ABBOTT, Scott Toner/HPD/Abbott@Exchange@ABBOTT, Shing Chang/LAKE/PPRD/ABBOTT@ABBOTT, Soneil Guptha/LAKE/HPD/ABBOTT@ABBOTT, Steve Fesik/LAKE/PPRD/ABBOTT@ABBOTT, Susan Rodriguez/HPD/Abbott@Exchange, Suzanne Lebold/HPD/Abbott@Exchange@ABBOTT, Terry J Oppenorth/LAKE/PPRD/ABBOTT@ABBOTT, Thomas G Moore/LAKE/HPD/ABBOTT@ABBOTT, Udo Legler/KNOLL-AG/BASF@KNOLL-AG, William Hargan/KNOLL-AG/BASF@KNOLL-AG, Wulff-Erik Von Borcke/NVP/MT-OLIVE/KNOLL-PHARMA/BASF@BASF-CORP

cc: Edward J Florentino/LAKE/PPD/ABBOTT@ABBOTT, William G Dempsey/LAKE/AI/ABBOTT@ABBOTT, Arthur J Higgins/LAKE/PPD/ABBOTT@ABBOTT, Dan W Norbeck/LAKE/PPRD/ABBOTT@ABBOTT, John M Leonard/LAKE/PPRD/ABBOTT@ABBOTT, Christopher B Begley [HPDAPP00.BEGLECB]@SSWGATE, Ed Ogunro/HPD/Abbott@Exchange, Steffen Roellinger/KNOLL-AG/BASF@KNOLL-AG, michael_williams@mckinsey.com

Subject: Pharma Strategy Retreat on May 2-4

We are excited about the upcoming Pharma Strategy Retreat on May 2-4. This will be the first opportunity that we will have had to step-back from the integration efforts and take a comprehensive look at the global pharma business we want to build together as part of the new Abbott.

Many of you have already been informed about the therapeutic area

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presentations for the retreat. The purpose of this message is to provide you with a more detailed overview of the objectives for the meeting and the criteria that will be used to compare different opportunities. This will be important context as you develop your presentations jointly with your co-chairs.

Retreat objectives

We have three major objectives for the meeting:

1. Gain a shared understanding of the opportunities for Abbott in each therapeutic area.
2. Select our core therapeutic areas for discovery and development moving forward.
3. Within these core therapeutic areas, identify the most important areas for focused discovery, development, licensing and commercial activity.

The goal of this meeting is not to finalize R&D project prioritization and budget allocations. However, the work we do together during the three days will be an important input to these decisions, which will be made by May 8th.

Criteria for assessment

As you prepare for your presentation, please use the following criteria to evaluate the opportunities in each therapeutic area.

Major criteria:

1. Chronic diseases with expanding global markets.
2. Scientific opportunity.
3. Unmet medical need.
4. Opportunities for synergies with devices and diagnostics.

Minor criteria:

1. Competitive landscape.
2. Experience and expertise at Abbott.
3. Fit with current marketed products or franchises.
4. Balance of low, medium and high-risk projects across the therapeutic areas.

Meeting agenda, presentations and templates

The final agenda for the meeting will be sent out in the next week. You should assume your presentation should take around 60 minutes, after which there will be approximately 30 minutes of discussion. For anti-infectives, oncology and neuroscience, the presentation time will be expanded to 90 minutes reflecting the breadth of diseases that will need to be addressed.

We have developed the templates for your presentations. These are not meant to restrict your creativity, but rather to ensure sufficient consistency across all of the presentations. Our hope is that you and your co-chairs will jointly act as strong advocates for your areas, focusing on the most important opportunities and challenges of your specific therapeutic area.

To kickoff this effort, a short meeting/conference call will be set up later this week with all of the TA co-chairs, during which I will provide additional context and guidance and address your initial questions. After this, please feel free to contact me directly if you have additional questions.

Attachments: (1) List of TA co-chairs, list of diseases by TA that should be addressed (not inclusive), (2) table of contents for TA presentations, and (3) templates



040901-team and TA lists.ppt 040801-outline for TA presentations.doc



040801-updated templates for R&D update.

Regards,

Jeff

SELECTION AND SCOPE OF INDIVIDUAL TA PRESENTATIONS

Ventures/TAs	In-scope areas (not inclusive)
1. Anti-infectives	• Antibacterials, anti-virals, anti-parasitics, antifungals, vaccines
2. Neuroscience	• Stroke, Parkinson's, epilepsy, migraine, Alzheimer's • Psychiatric diseases, Attention deficit disorder
3. Pain/NSAIDS	• Neuropathic pain, chronic pain, NSAIDs • Narcotic analgesia, other analgesia, acute pain
4. Cardiovascular/ thrombosis	• Hypertension, CHF, hyperlipidemia, MI • Stroke, unstable angina, anti-coagulants
5. Urology	• BPH, erectile dysfunction, incontinence
6. Diabetes/obesity/ metabolism	• Diabetes, diabetic complications, obesity, thyroid • All tumors and all pharmaceutical approaches
7. Oncology	• RA/OA, psoriasis, transplantation, MS, Crohn's, sepsis, asthma
8. Immunoscience	• Injectibles, inhalation agents, neuromuscular blockers, anti-emetics, anxiolytics etc
9. Anesthesia	• Vitamin D analogues, erythropoiesis, iron therapy
10. Renal Care	

D

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TEAMS TO DEVELOP TA PRESENTATIONS

TAs	Co-leaders (joint team)	Other team members*
1. Anti-infectives	<ul style="list-style-type: none"> Clinical - E. Sun - clinical Discovery S. Chang Commercial - Ron Lloyd (AI); Jerry Wenker (PPD) 	<ul style="list-style-type: none"> N/a
2. Anti-viral	<ul style="list-style-type: none"> Clinical - E. Sun Discovery - S. Chang Commercial - Frank Zhou (AI); Mark Webster (PPD) 	<ul style="list-style-type: none"> n/a
3. Neuroscience	<ul style="list-style-type: none"> Clinical - Iris Loew-Frickel Discovery - J. Sullivan Commercial - Rock Marasco (PPD); J. Arnott to assign (AI) 	<ul style="list-style-type: none"> n/a
4. Pain	<ul style="list-style-type: none"> Clinical - M. Verlinden/Charlie McLeskey (HPD) Discovery - Jim Sullivan Commercial - John Heden (HPD); Ralf Krautheimer (AI); Paul Bems (PPD) 	<ul style="list-style-type: none"> Commercial Ron Lloyd (AI)
5. Cardiovascular/ thrombosis	<ul style="list-style-type: none"> Clinical - Suneil Gupta (HPD); Iris Loew-Friedrich Discovery - F. Frickel; John Toner (HPD) Commercial - S. Lebold (HPD); Udo Legler and Michael Kirchengast (AI) 	<ul style="list-style-type: none"> Commercial - Mary Szela (HPD)
6. Urology	<ul style="list-style-type: none"> Clinical - M. Verlinden Discovery - J. Sullivan Commercial - Johan Baeck (AI); Bob Altman (PPD) 	<ul style="list-style-type: none"> n/a

* Co-leaders should broadly leverage expertise from across the Abbott and x-Knoll organizations

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HOPFIELD Dep. Ex. 10 / PLs' FR

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Resource Allocation Across GPRD



Abbott Laboratories

Discussion document

May 5, 2001

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CH-CH-228013-013jb/aard

CONTENTS

- Synergy targets and opportunities identified to date
- Potential savings by TA and project in development
- Potential savings by TA and project in discovery
- Functional area and site budgets
- Decision templates
- Appendix

CH-CH-228013-013jb/aaRD

SUMMARY


- Synergies* of \$63 million required in 2001 and \$79 million in 2002
- Potential synergies of \$64 million already identified
 - \$29 million from R&D sub-teams
 - \$35 million from rationalization of low-rated projects (those rated terminated, hold, or pending) based on development reviews (\$16 million internal, \$19 million external)

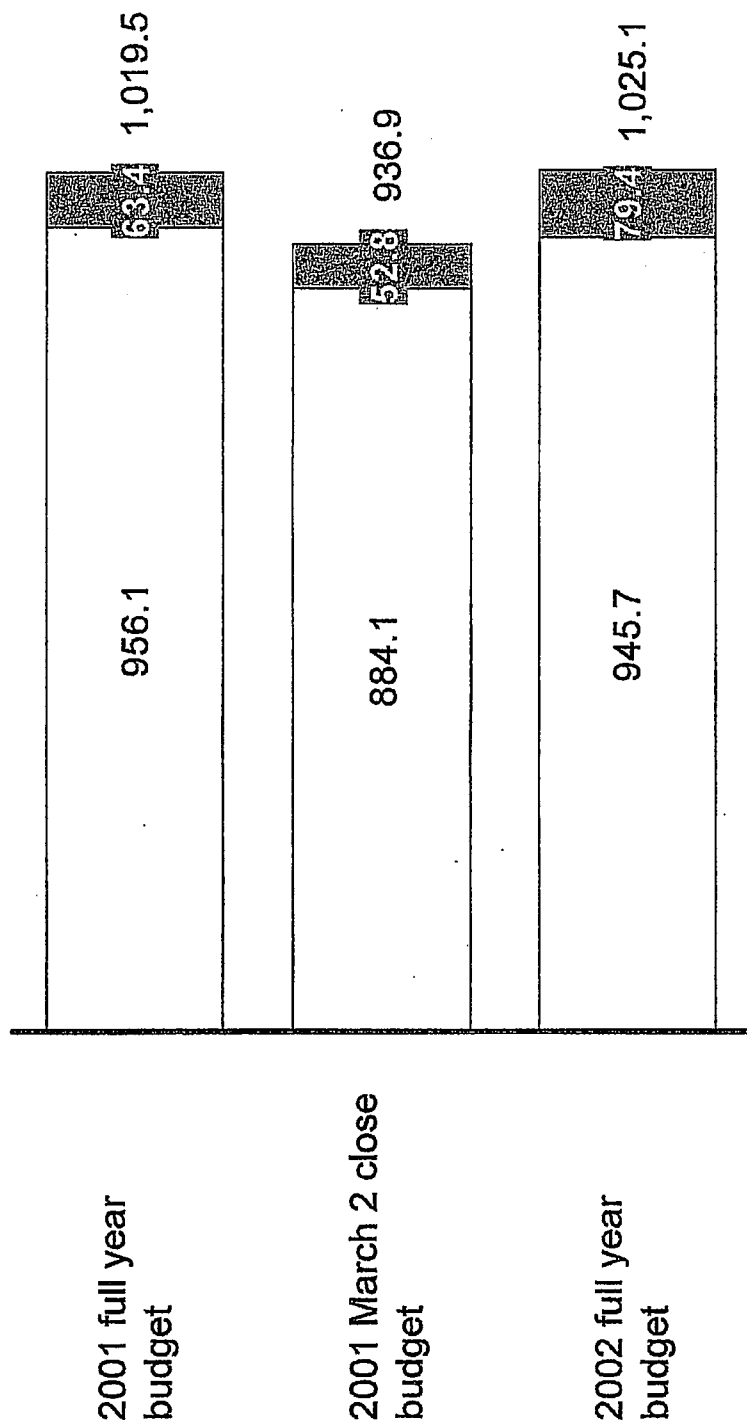
* Excludes affordability

CH-CH-228013-013jb/aaRD

GPRD BUDGET AND SYNERGY TARGETS

\$ Millions

 Synergy target



Source: GPRD Finance

CH-CH-228013-013j/aaRD

SYNERGIES IDENTIFIED TO DATE

Percent; \$ millions

PRELIMINARY

	Percent of 2001 target achieved	Target 2001	Synergies		Cumulative headcount reductions	
			2001	2002	2001	2002
Regulatory affairs / QA	180	0.5	0.9	1.9	7	7
Data manage- ment / statistics	173	1.5	2.6	2.8	38	38
Medical affairs	120	1.5	1.8	3.4	26	26
CMC	105	10.0	10.5	21.6	207	184
IM&T	103	3.0	3.1	5.1	6	6
Phase I	100	1.0	1.0	2.5	7	8
Other (admin., etc)	100	2.0	2.0	3.3	0.2	0.2
Venture/global team management	100	4.5	4.5	8.9	93	93
Drug safety	70	3.0	2.1	3.6	15	15
Discovery	23	3.0	0.7	4.2	29	29
Total	97	30.0	29.2	57.3	430	408

Source: Synergy templates submitted by sub-teams

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CH-CH-228013-013b/aaRD

PRELIMINARY**DESCRIPTION OF SYNERGIES**

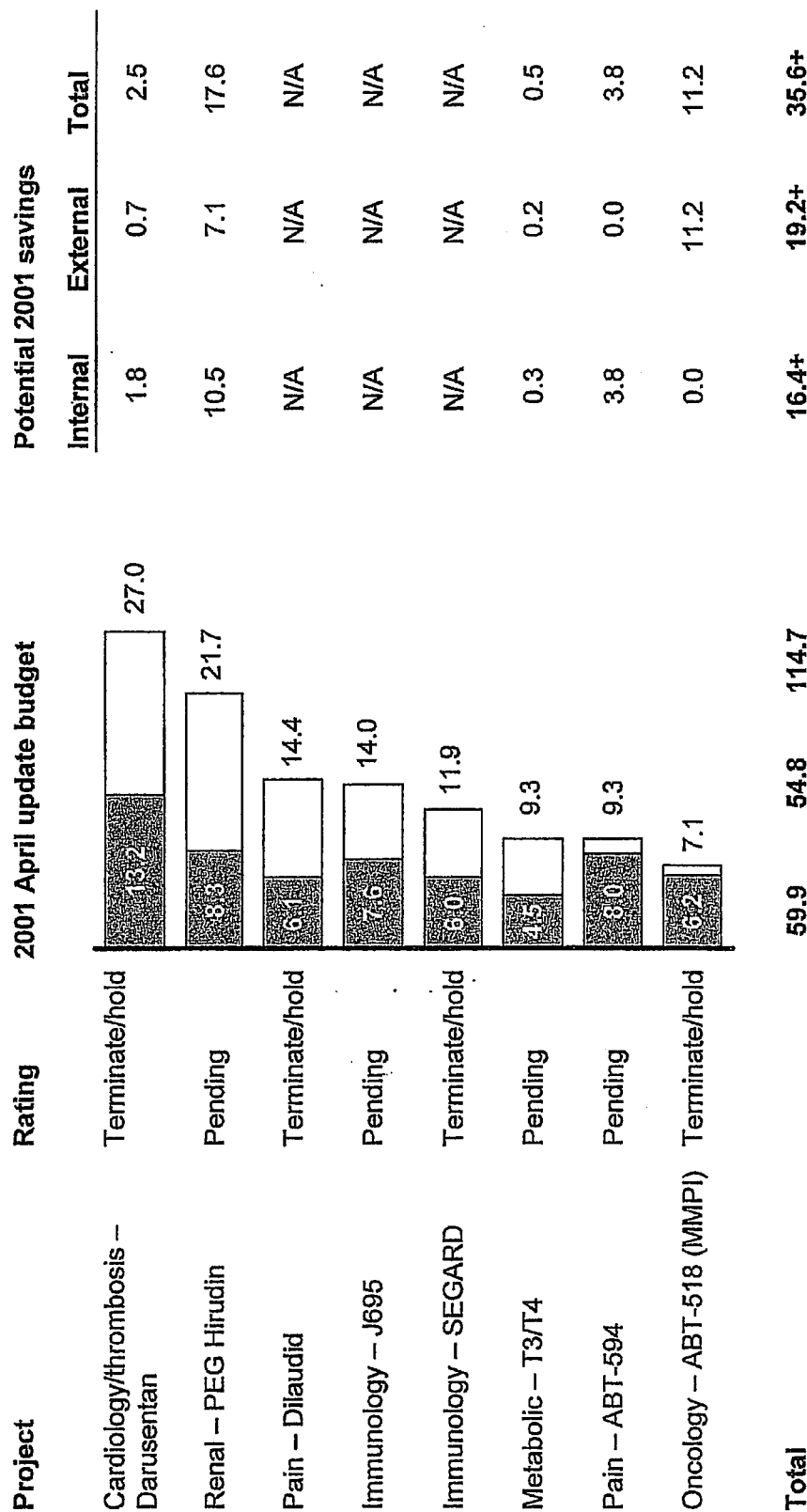
Function	Key initiatives
Data management/statistics	<ul style="list-style-type: none"> • Reduce head count globally, especially in Mt. Olive • Insource planned contracted work for Phase IV studies
Medical affairs	<ul style="list-style-type: none"> • Reduce global head count in marketed product development • Consolidate medical information personnel • Reduce health outcomes personnel in Ludwigshafen
CMC	<ul style="list-style-type: none"> • Close chemical plant in Ludwigshafen • Exit all CMC activities at Whippy and Italy • Eliminate redundancies in PAR, PPD clinical packaging, and PPD QA • Increase formulation activities at Ludwigshafen
IM&T	<ul style="list-style-type: none"> • Cancel emerging dossier projects • Reduce U.S. R&D IT infrastructure costs
Phase I	<ul style="list-style-type: none"> • Increase utilization of Waukegan and Ludwigshafen Phase I units through right of first refusal for studies • Reduce head count globally
Other (Admin., etc.)	<ul style="list-style-type: none"> • Consolidate services purchased
Regulatory affairs/QA	<ul style="list-style-type: none"> • Reduce global head count and operating expenses
Venture/global team management	<ul style="list-style-type: none"> • Reduce head count in Mt. Olive and Canada • Optimize resources and internalize work
Drug safety	<ul style="list-style-type: none"> • Reduce external costs by shifting contracted work in Europe to Abbott Park • Consolidate radiochemistry at Abbott Park
Discovery	<ul style="list-style-type: none"> • Consolidate high throughput screening at Abbott Park

Source: Synergy templates submitted by sub-teams

CH-CH-228013-013/aaRD

POTENTIAL SAVINGS FROM LOW-RANKED PROJECTS**\$ Millions**PRELIMINARY

☐ External
☒ Internal



Note: Expected 2002 budget is \$179.3 million

Source: GPRD Finance; development review

CH-CH-228013-013b/aaRD

INITIAL PORTFOLIO PRIORITIZATION

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Anti-infectives ABT-492	C	<ul style="list-style-type: none"> Address safety issues (including QTc) with internal/ expert review Determine how many indications at launch (pay back) 	• J. Leonard	-
HSR-903	T	<ul style="list-style-type: none"> Consider trading with Daiichi Halt any new expenditure 	• J. Tyree	-
ABT-773	C	<ul style="list-style-type: none"> Assess side effects issues with expert review (QTc and liver tox.) Ensure all drug interactions are adequately covered Assess relative to Ketek 	<ul style="list-style-type: none"> • J. Leonard • J. Leonard • I. Loew-Friedrich 	-
Urology BSF 420627	P	<ul style="list-style-type: none"> Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> Reasons for failure of the SKB ETa/b antagonist Design short (~4 week) PoP trial for symptom relief Rationale for sustained release formulation Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May
Hypothyroidism T3/T4	P	<ul style="list-style-type: none"> Assess most appropriate ratio Gain FDA feedback on study design Determine ex-US market attractiveness (price) 	• J. Leonard	• By May
Asthma Hokunalin tape	P	<ul style="list-style-type: none"> Conduct market research on acceptance by different patient segments Determine how to position against long acting beta agonists and combination inhalers Evaluate opportunity to gain complete access to the patch technology 	<ul style="list-style-type: none"> • A. Higgins/ E. Fiorentino • J. Tyree 	• May

CH-CH-228013-013b/aarD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> Pursue proof of concept Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> As planned
ABT-751	C	<ul style="list-style-type: none"> Pursue proof of concept Use echocardiogram to monitor potential cardiotoxicity Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> Project team CMC group 	<ul style="list-style-type: none"> As planned
ABT-518	Hold/T	<ul style="list-style-type: none"> Wait for May results from Pfizer (will save ~\$1mil) and re-evaluate Halt all further expenditure 	<ul style="list-style-type: none"> Senior management 	<ul style="list-style-type: none"> May
Rubitecan	P	<ul style="list-style-type: none"> Significant clinical rework required (funded by partner)- further in-depth review required Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
Theragyn	P	<ul style="list-style-type: none"> Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> Determine if there is a PoC to support claim Address GMP issues Determine best control to demonstrate efficacy Re-look at partnership contract 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> By May
ABT-627	C	<ul style="list-style-type: none"> Seek alternative funding (e.g., NCI) before starting major trial if move ahead <ul style="list-style-type: none"> Determine how to ensure NDA filing in 2004 Get FDA input since survival not primary endpoint Harmonize US and EU study design and inputs Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> J. Tyree J. Leonard, P. Nisen 	<ul style="list-style-type: none"> By May ASAP
			<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> By May

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darsentan (LU 135252)	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) Consider out-license or swap 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing
LU 208075	Hold/T	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> ASAP
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro B. Dempsey 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing

CH-CH-228013-013/b/aarD

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial -- probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTC • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew-Freidrich • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • I. Loew-Freidrich 	<ul style="list-style-type: none"> • As above
BSF 74398	C (no cost)	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold/T	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	<ul style="list-style-type: none"> • E. Fiorentino 	<ul style="list-style-type: none"> • By June
TU-199	T	<ul style="list-style-type: none"> • Terminate outside Japan 	<ul style="list-style-type: none"> • Bob Funck • Project team 	<ul style="list-style-type: none"> • By May • Immediate
AU-224	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • E. Fiorentino 	<ul style="list-style-type: none"> • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Leonard's group (already in process) - 1/2 day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DMARD claim in first submission - Assess need for Enbrel assay to detect HAHA's - Assess delivery device options - Evaluate additional indications (e.g., psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various 	<ul style="list-style-type: none"> • By May • By May
			<ul style="list-style-type: none"> • J. Tyree 	

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

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INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- Continue
P- Pending
T- Terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• None identified	-	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	<ul style="list-style-type: none"> • Conduct commercial assessment for CNS and depression (P&L) • Assess combination therapy with fibrates • Assess outcomes trial design to meet preferred commercial profile; determine payback 	<ul style="list-style-type: none"> • B. Dempsey, J. Arrott, E. Fiorentino • Project team 	<ul style="list-style-type: none"> • ASAP
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

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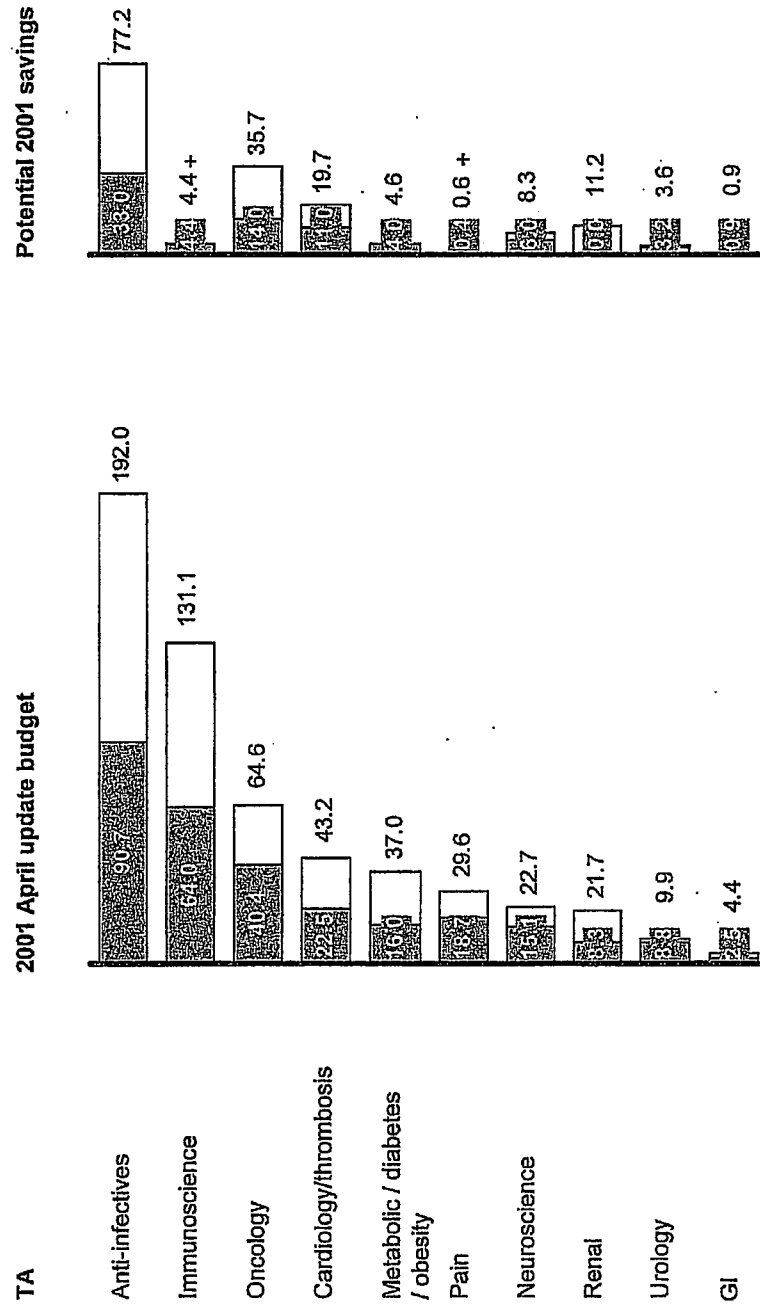
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POTENTIAL DEVELOPMENT PROGRAM SAVINGS IN 2001 IF TA TERMINATED

\$ Millions

External
Internal



Note: Because of incomplete survey responses assumes limited savings from sibutramine, B201640, T4/T3, Synthroid, Vicoprofen, Dilaudid, Hydrocodone, PEG-Hirudin, and BSF 420627

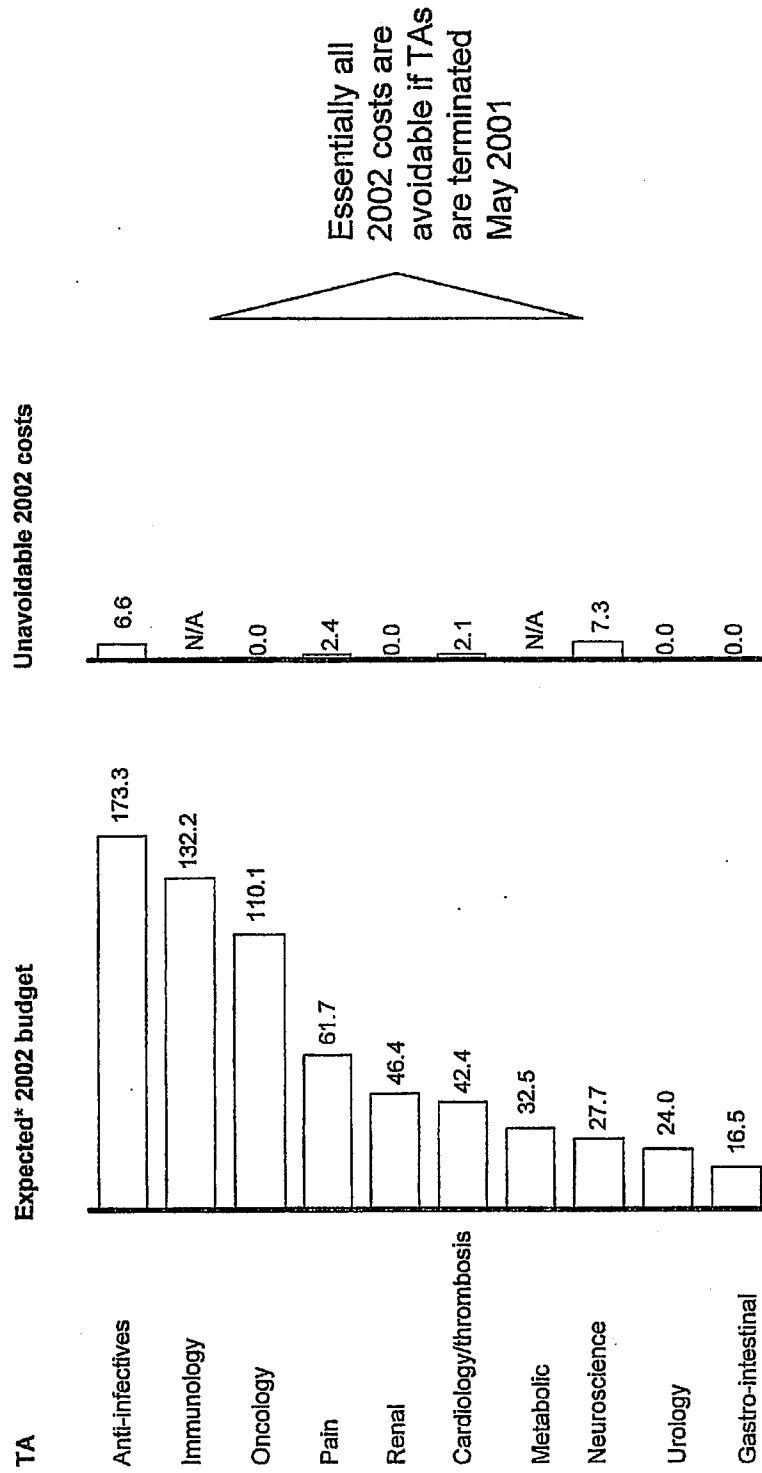
Source: GPRD Finance

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POTENTIAL DEVELOPMENT PROGRAM SAVINGS IN 2002 IF TA TERMINATED

\$ Millions



* Risk adjusted

Note: N/A means not available

Source: GPRD Finance

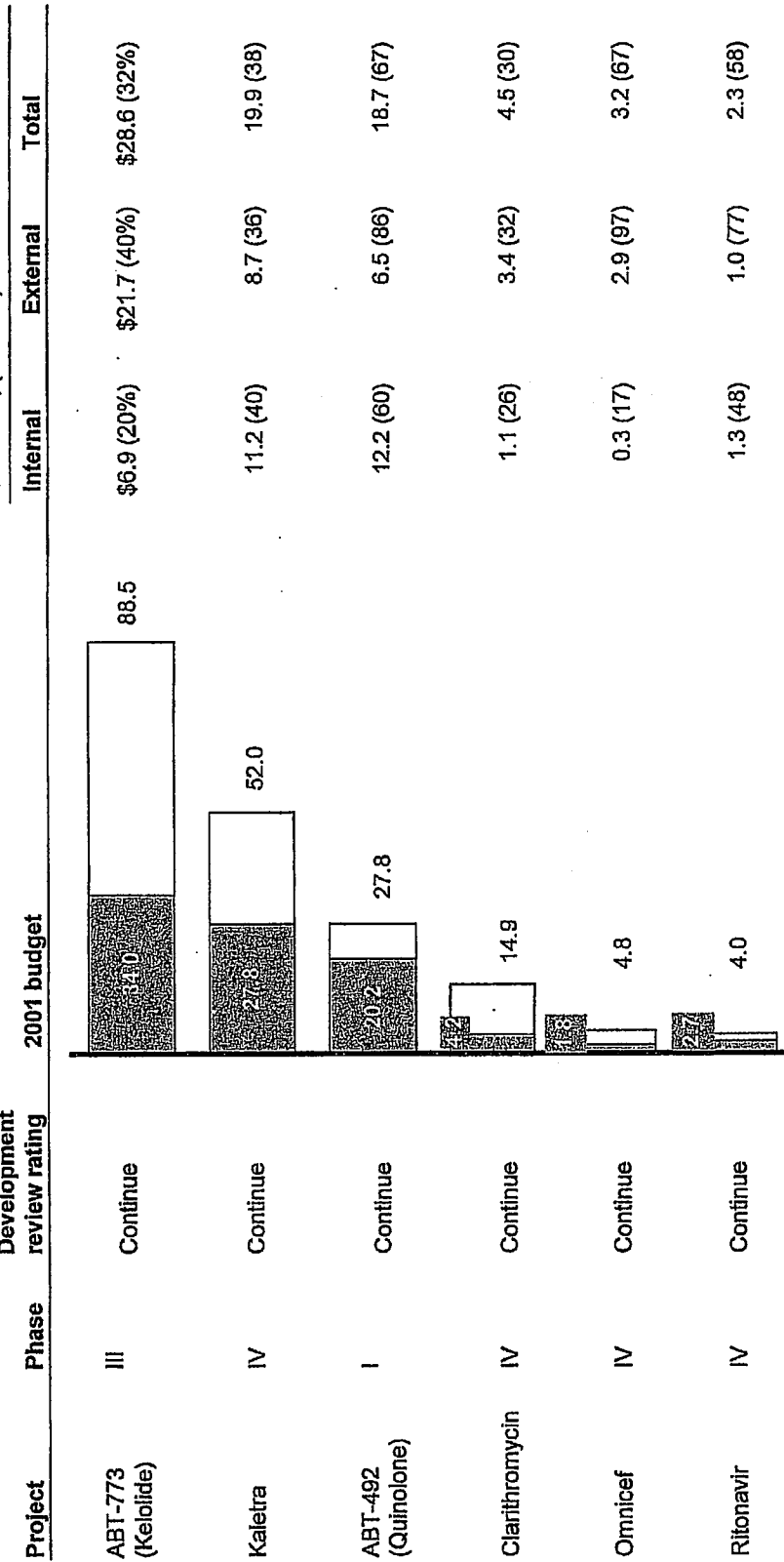
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POTENTIAL SAVINGS – ANTI-INFECTIVES

\$ Millions

□ External
 ■ Internal

2004 potential savings
 \$ Millions, (Percent)



Source: GPRD Finance

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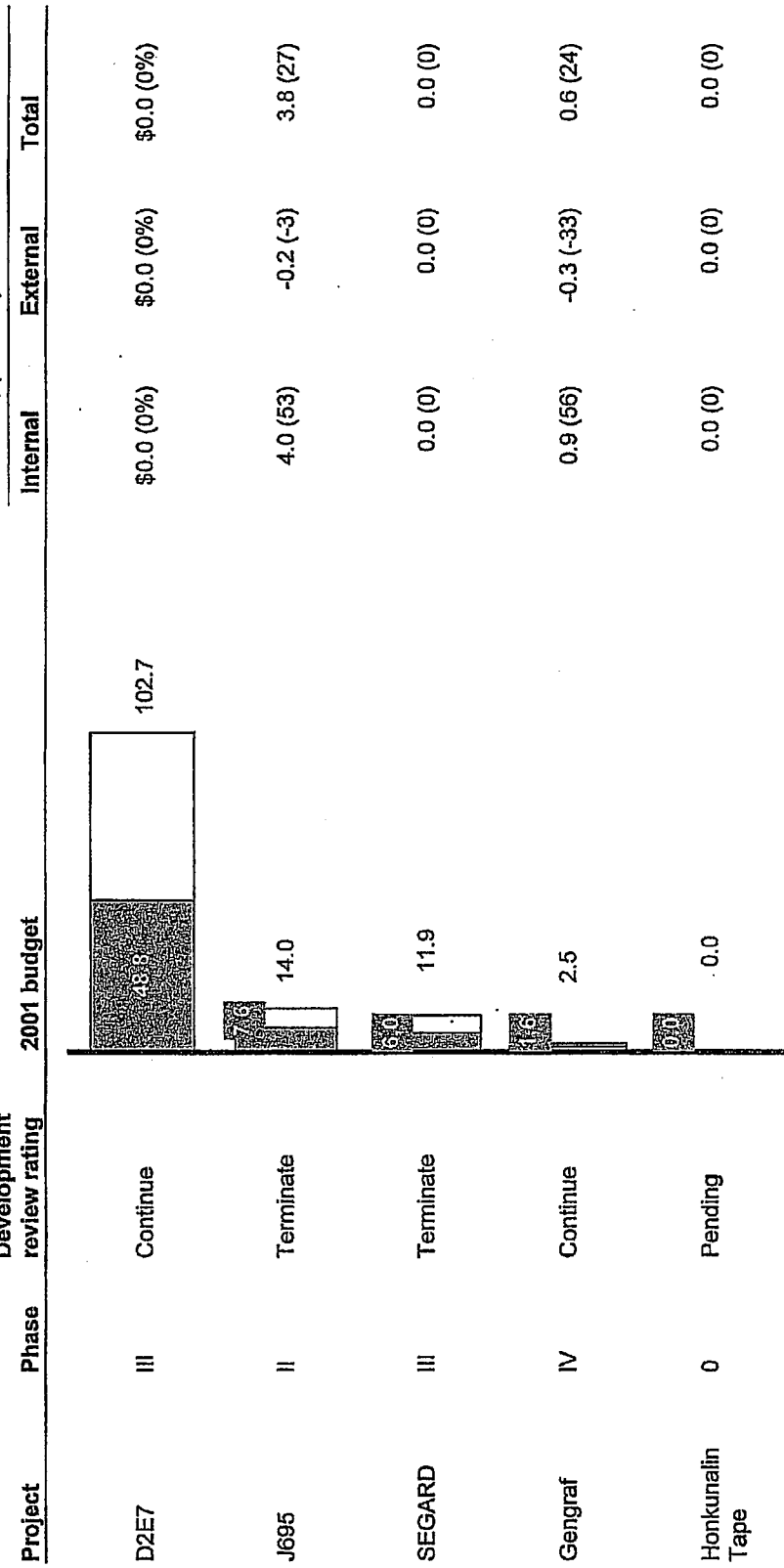
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POTENTIAL SAVINGS – IMMUNOLOGY

\$ Millions

□ External
 ■ Internal

2001 potential savings
 \$ Millions, (Percent)



Source: GPRD Finance

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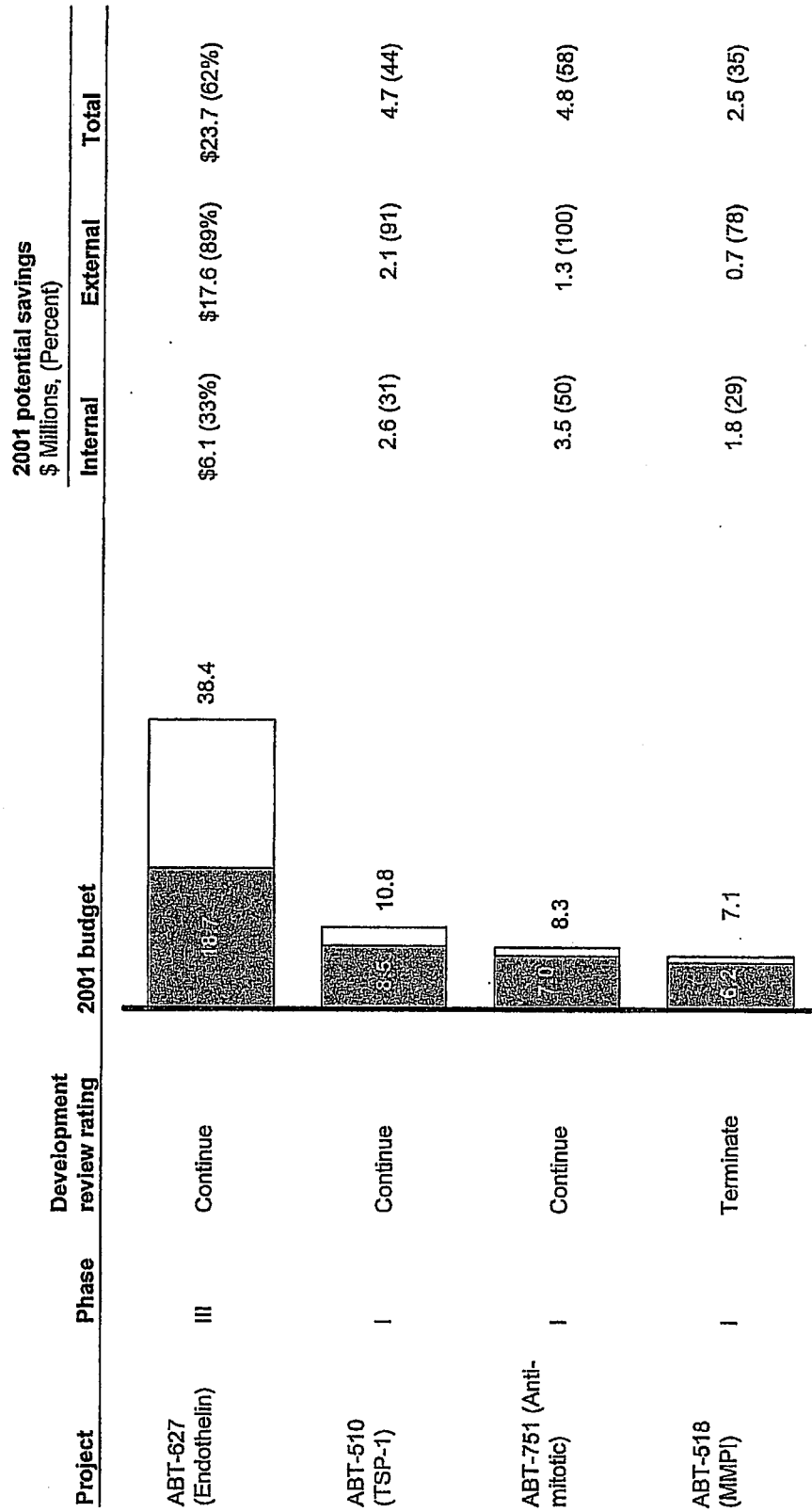
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POTENTIAL SAVINGS – ONCOLOGY \$ Millions

☐ External
☒ Internal



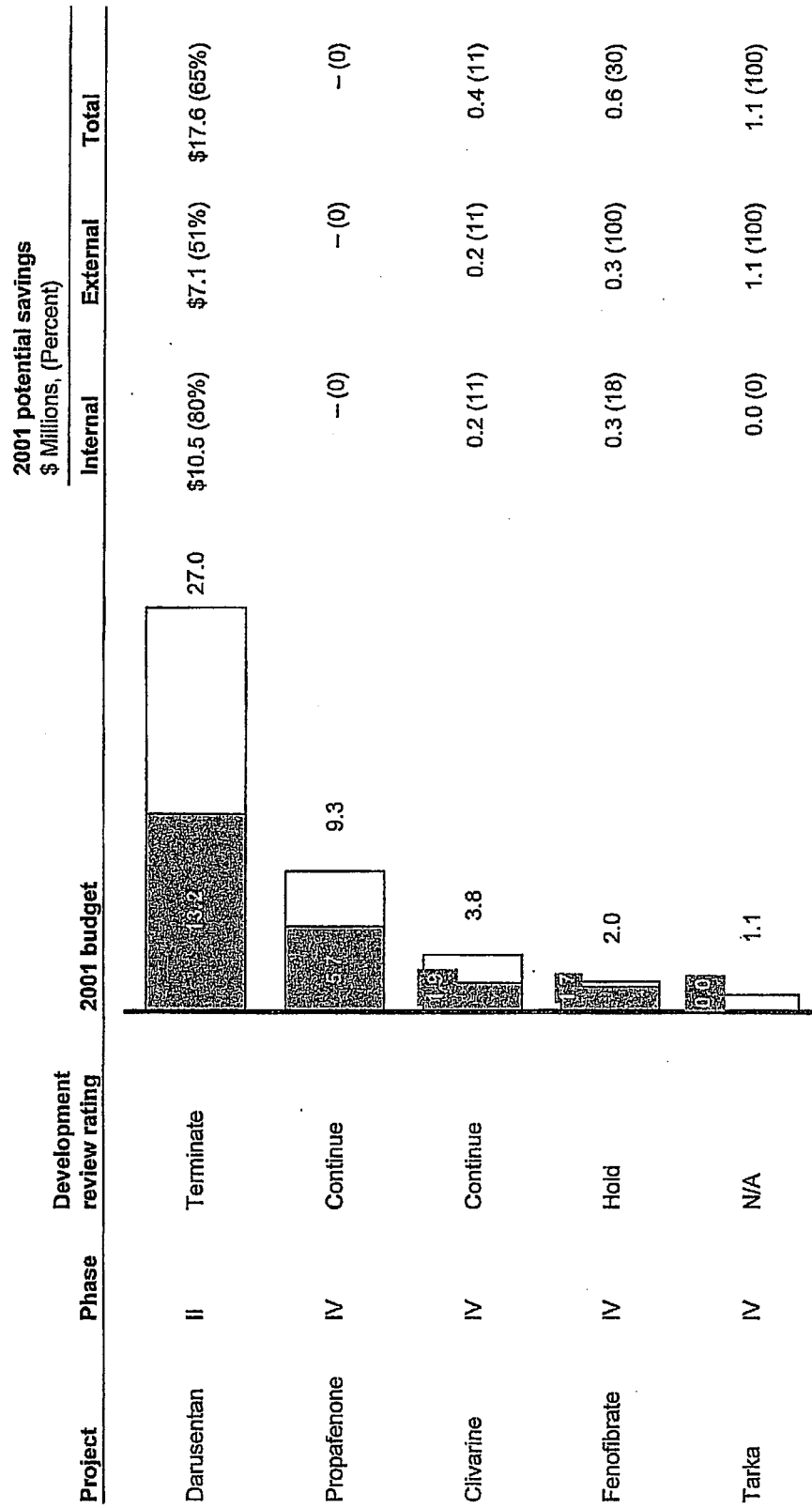
Source: GPRD Finance

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POTENTIAL SAVINGS – CARDIOLOGY/THROMBOSIS \$ Millions

□ External
■ Internal



Source: GPRD Finance

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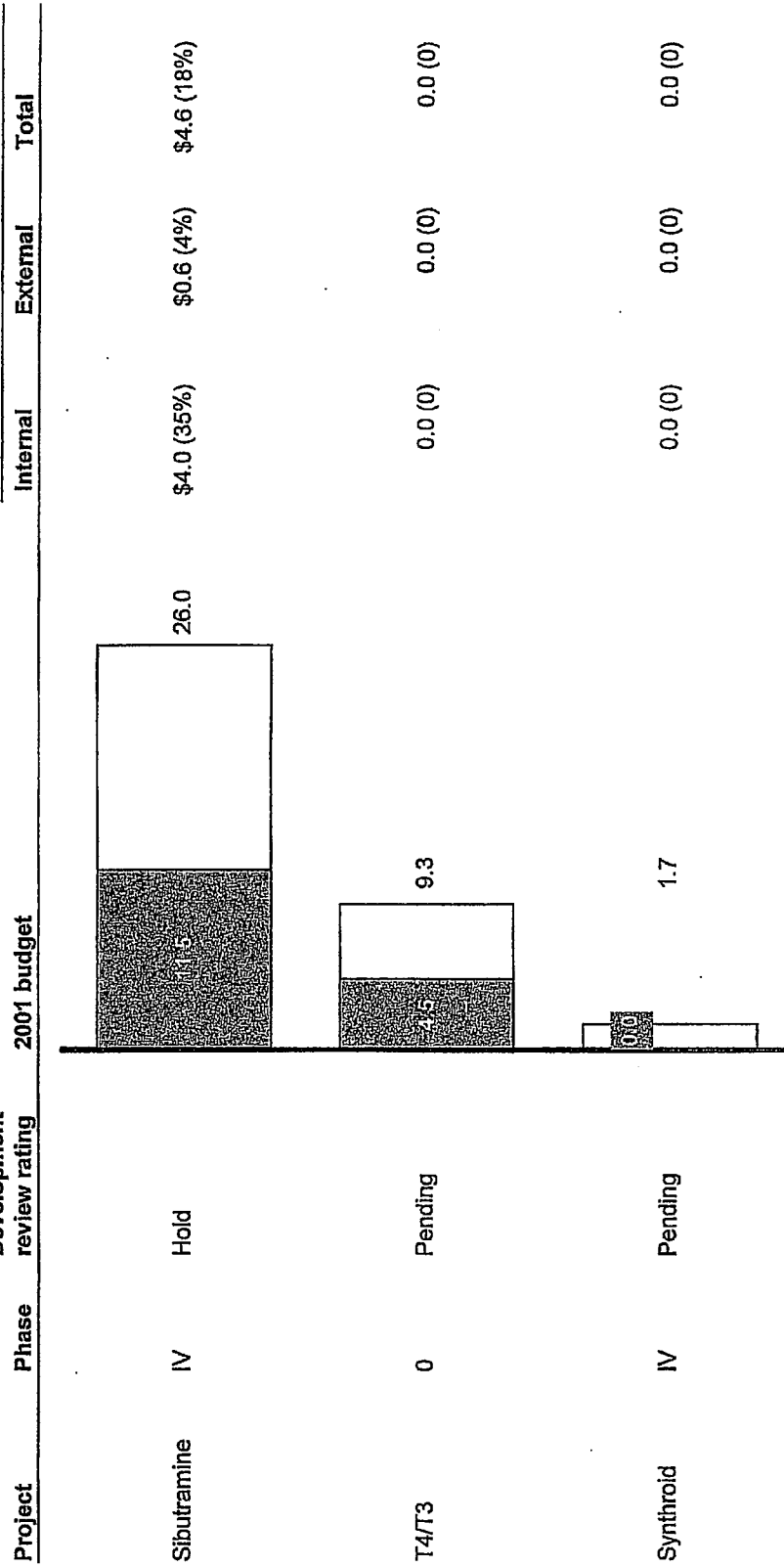
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POTENTIAL SAVINGS – METABOLIC / DIABETES / OBESITY

\$ Millions

External
Internal

2001 potential savings
\$ Millions, (Percent)



Source: GPRD Finance

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CONFIDENTIAL

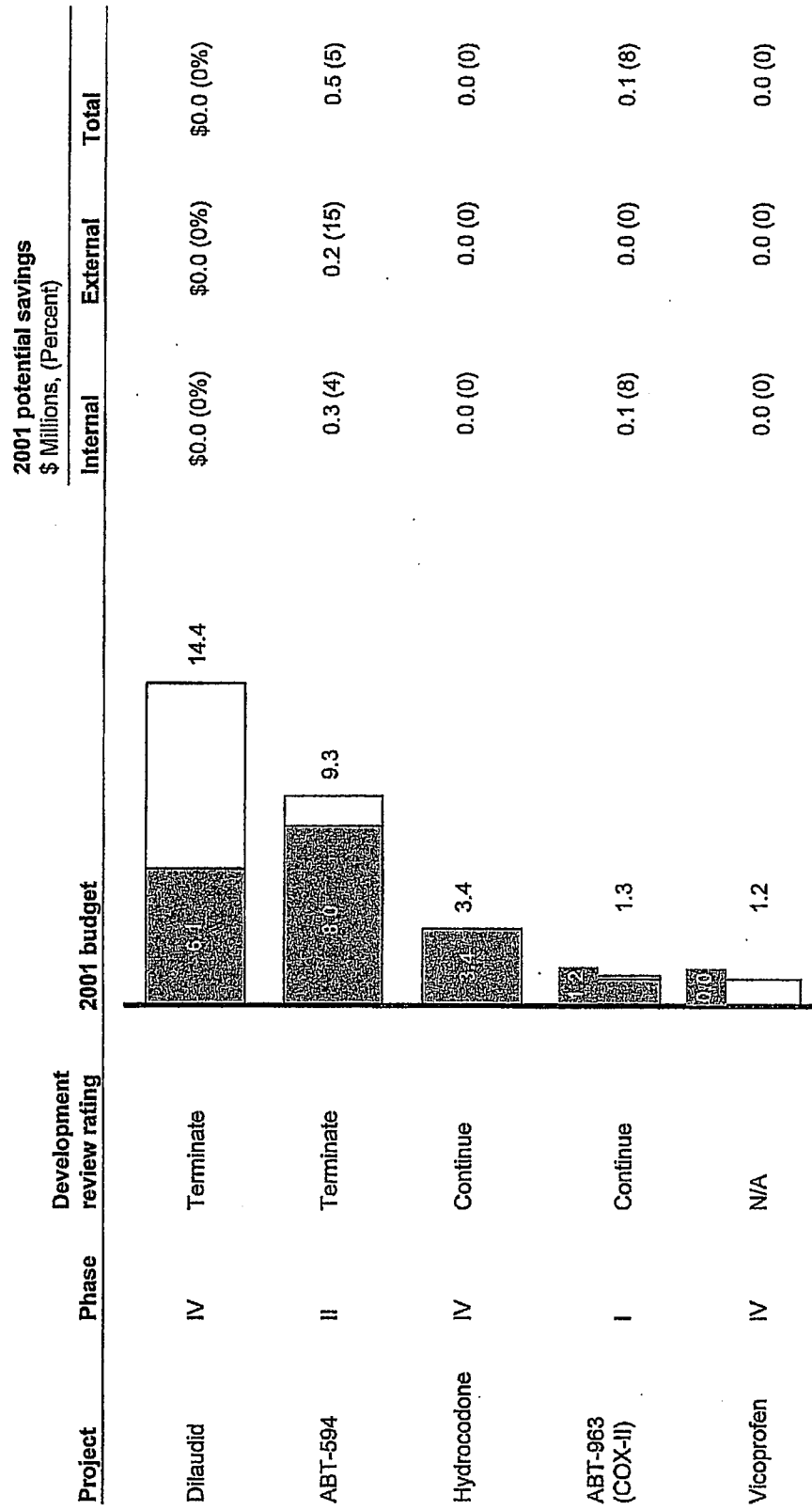
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CH-CH-228013-013/b/aARD

POTENTIAL SAVINGS – PAIN

\$ Millions

□ External
 ■ Internal



Source: GPRD Finance

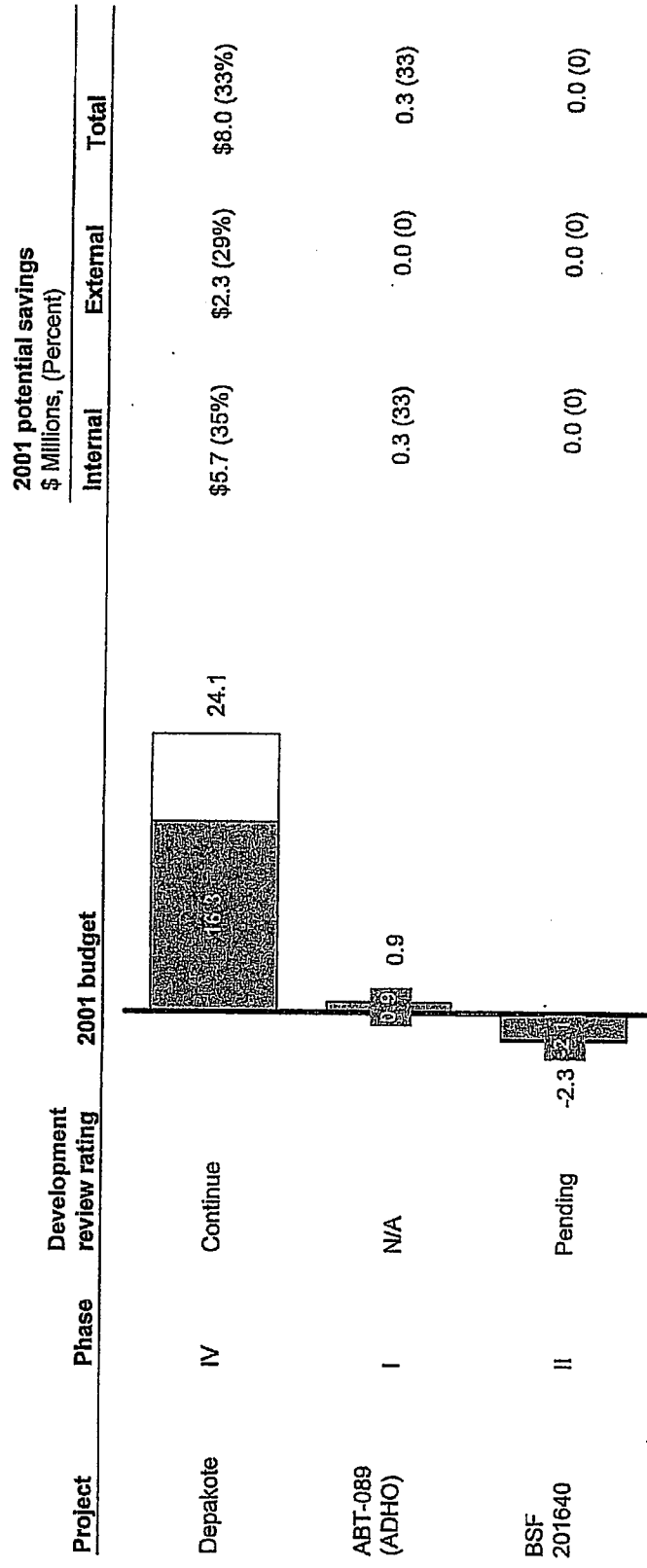
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POTENTIAL SAVINGS – NEUROSCIENCE

\$ Millions

External
Internal



Source: GPRD Finance

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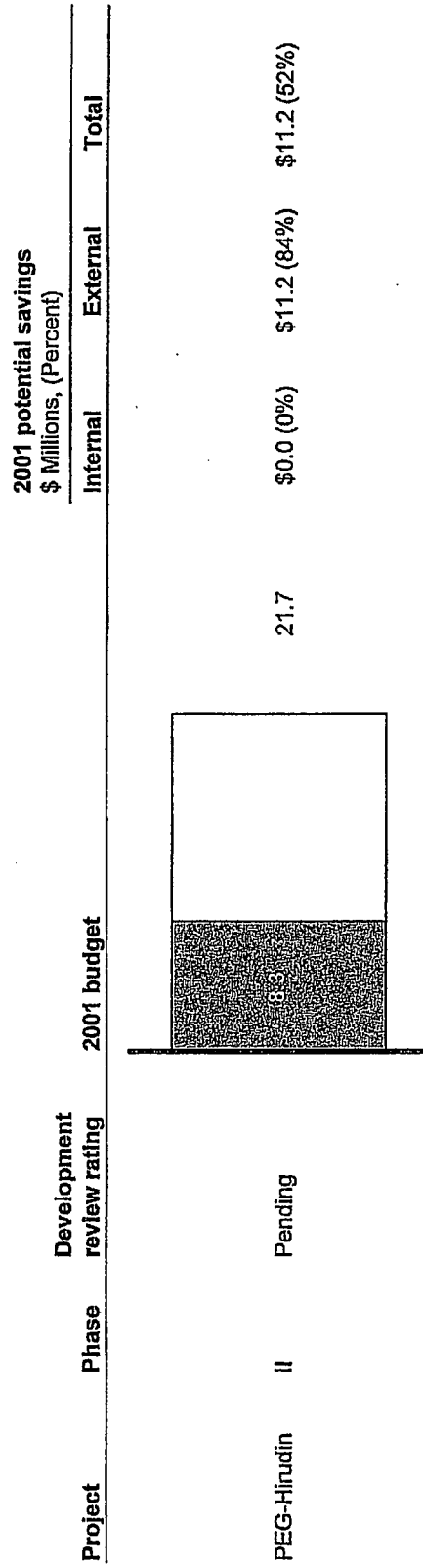
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POTENTIAL SAVINGS – RENAL \$ Millions

☐ External
☒ Internal



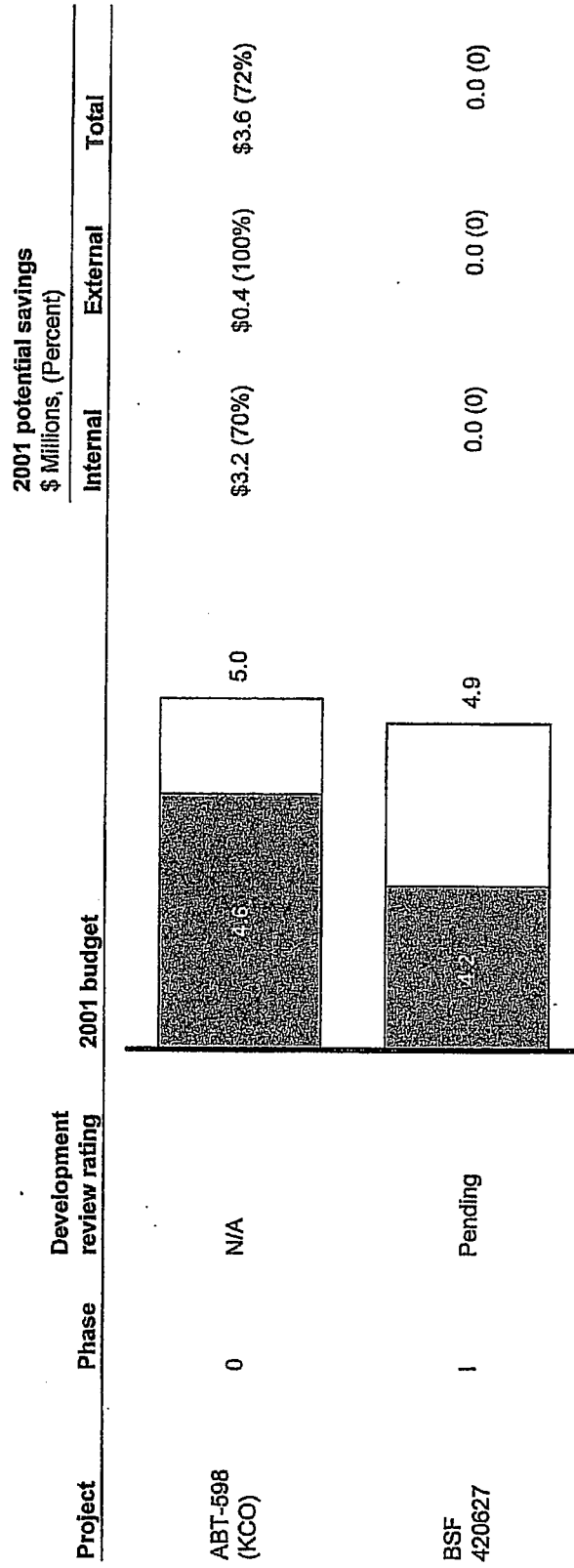
Source: GPRD Finance

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POTENTIAL SAVINGS – UROLOGY

\$ Millions

External
Internal



Source: GPRD Finance

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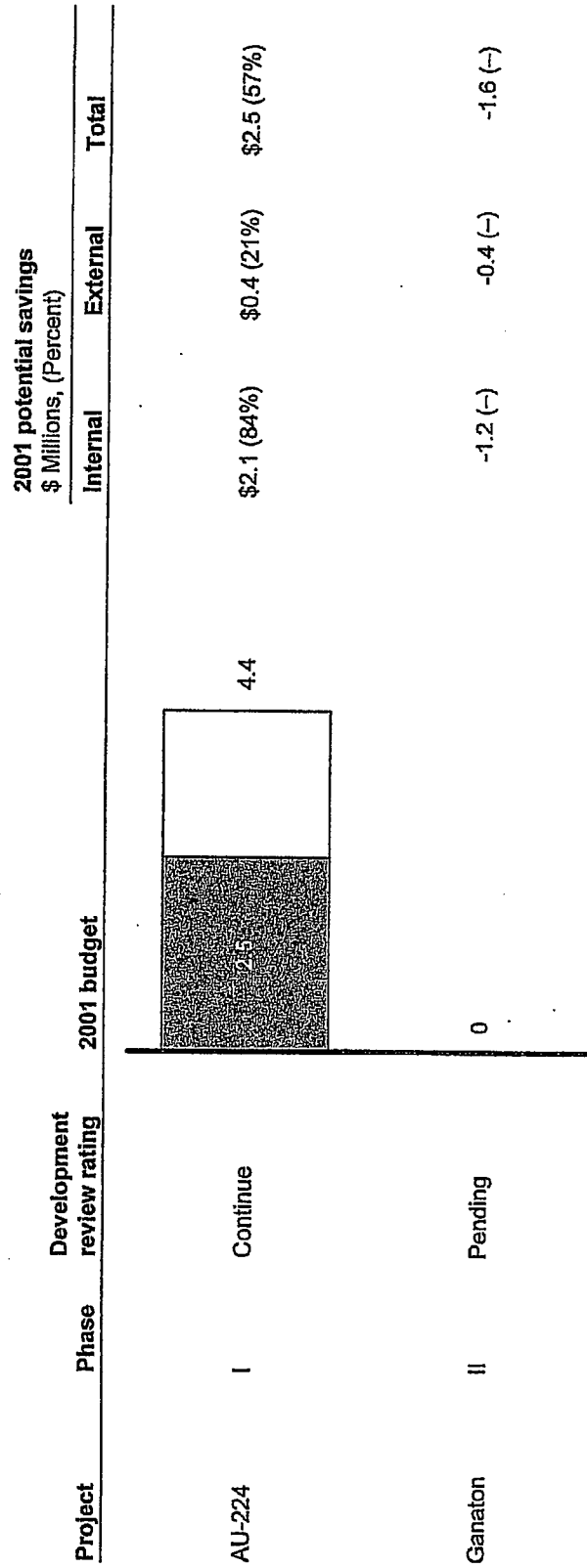
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POTENTIAL SAVINGS – GI \$ Millions

□ External
■ Internal



Source: GPRD Finance

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CONFIDENTIAL

MCK 00230

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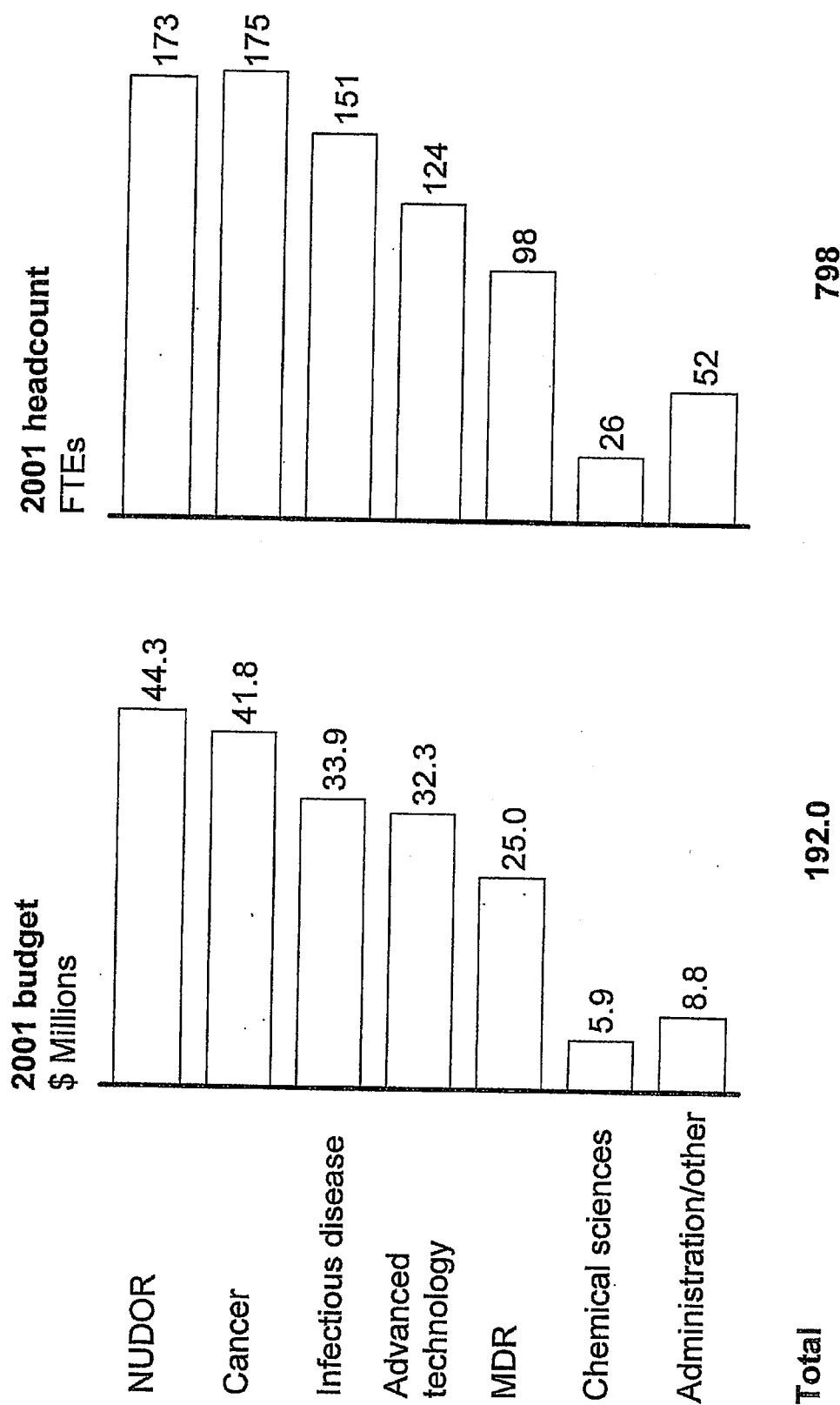
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APRIL UPDATE

ABBOTT PARK DISCOVERY – OVERVIEW \$ Millions; FTE

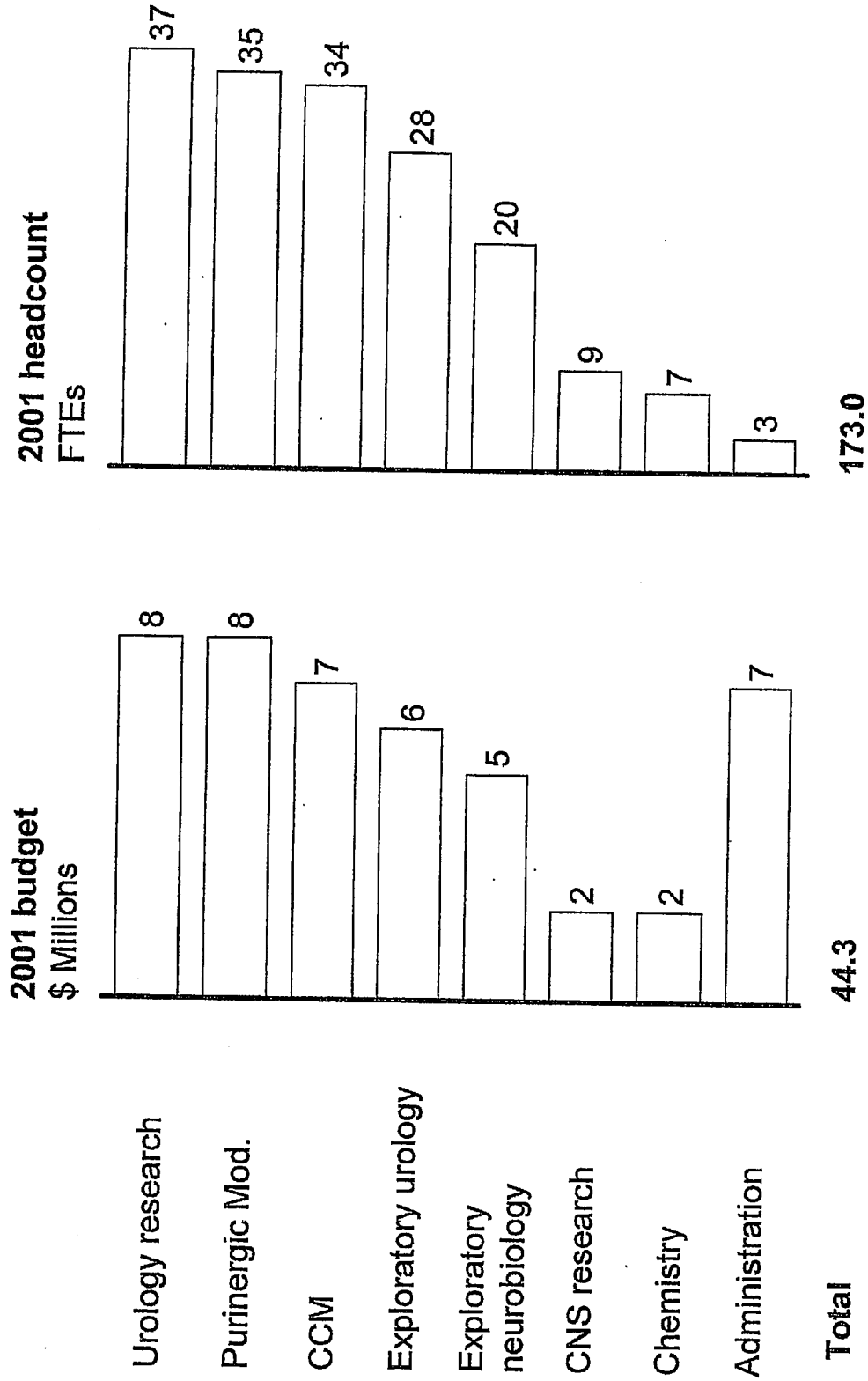


Source: GPRD Finance

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PRELIMINARY

ABBOTT PARK DISCOVERY – NUDOR \$ Millions; FTE



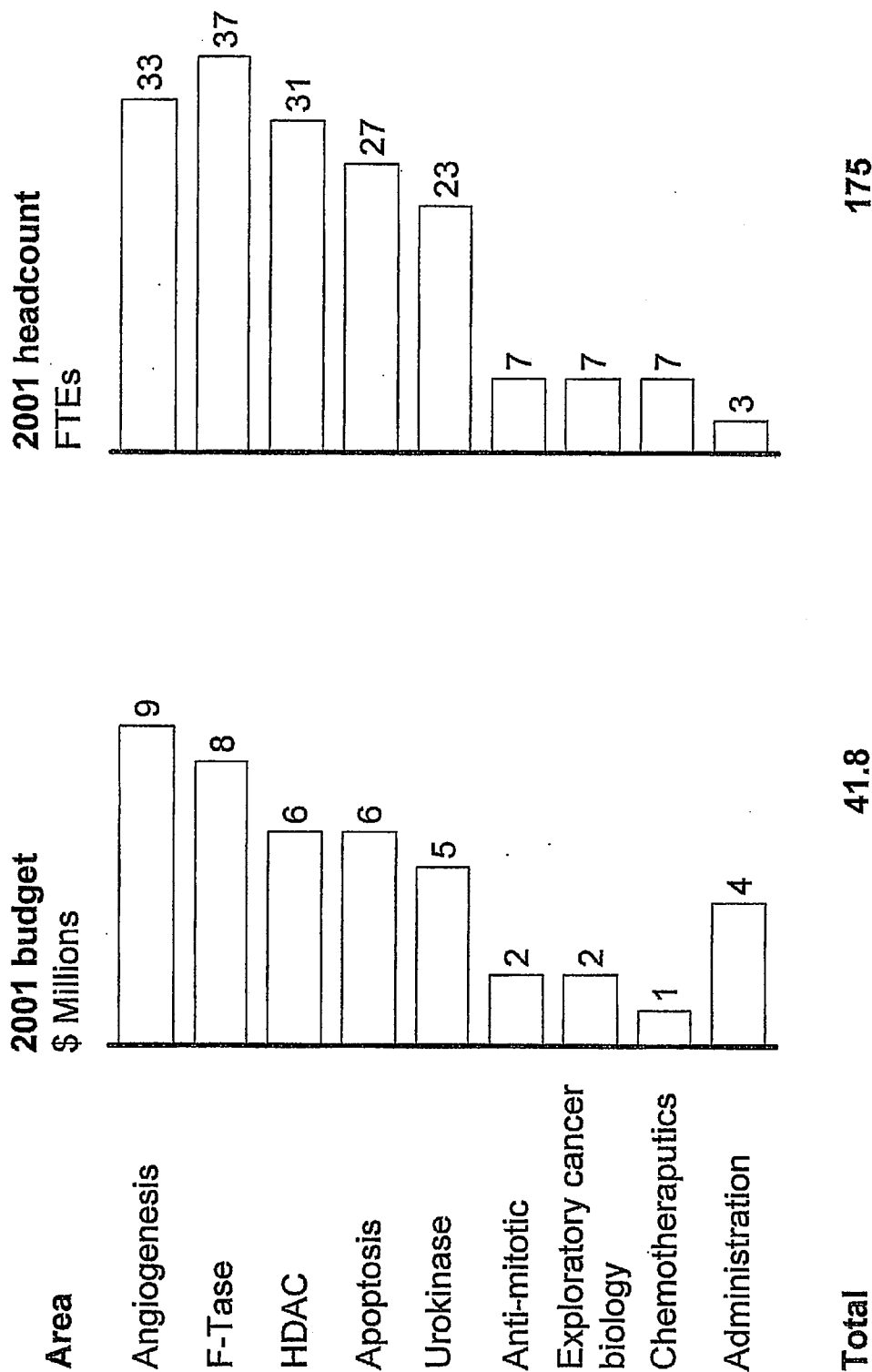
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APRIL UPDATE

ABBOTT PARK DISCOVERY – CANCER

\$ Millions; FTE



Source: GPRD Finance

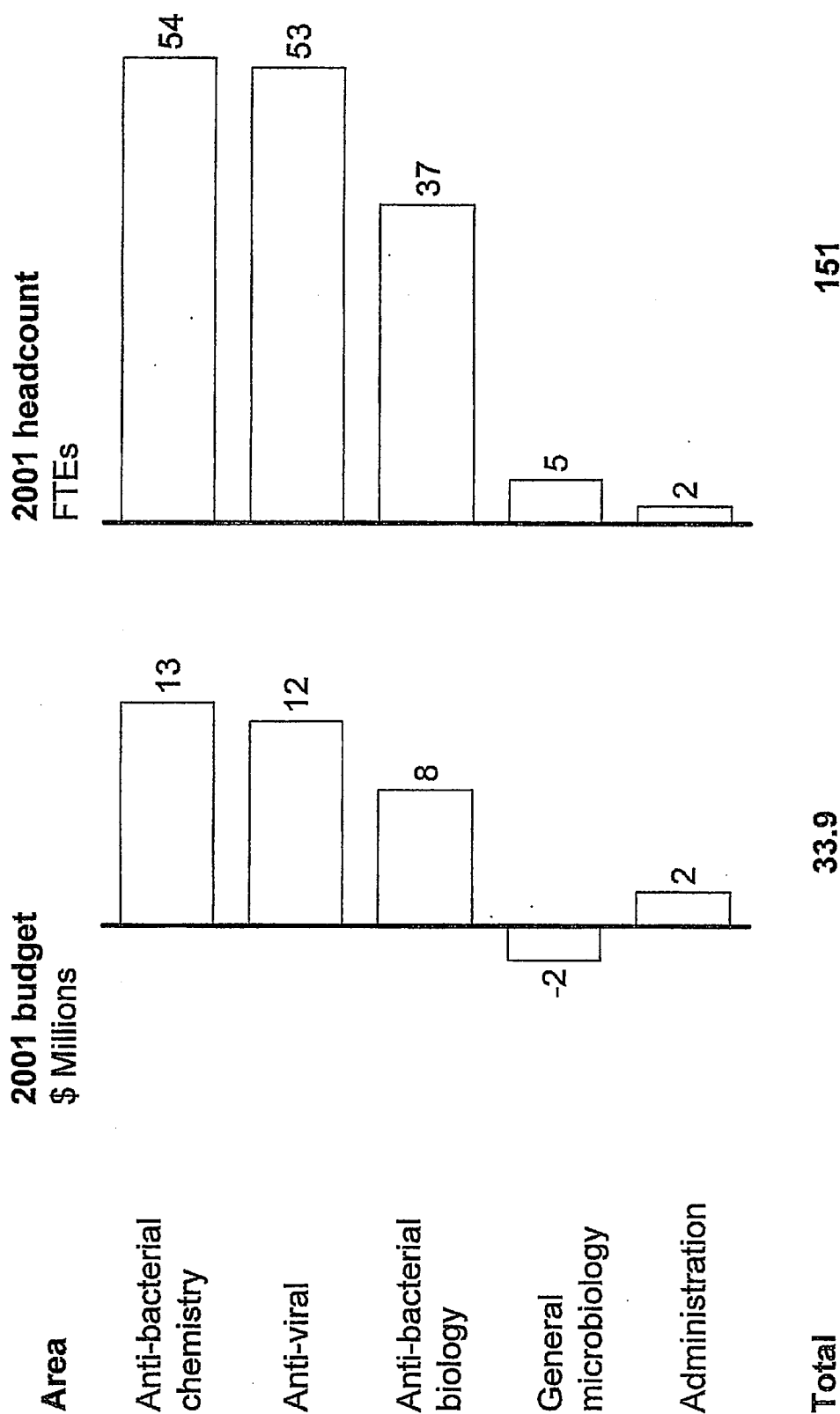
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ABBOTT PARK DISCOVERY – INFECTIOUS DISEASE

\$ Millions; FTE

APRIL UPDATE



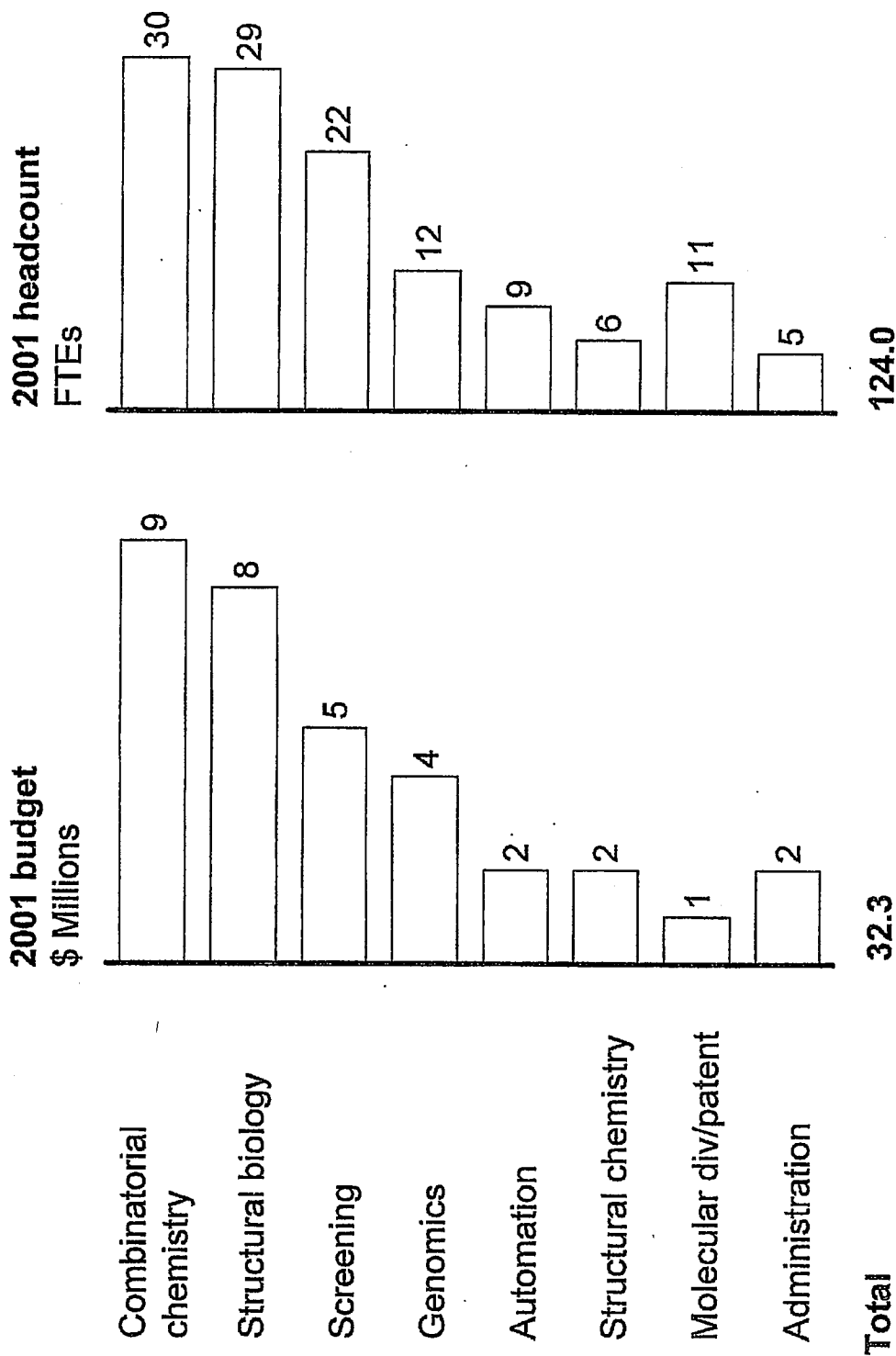
Source: GPRD Finance

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ABBOTT PARK DISCOVERY – ADVANCED TECHNOLOGY

\$ Millions; FTE

PRELIMINARY

Source: GPRD Finance

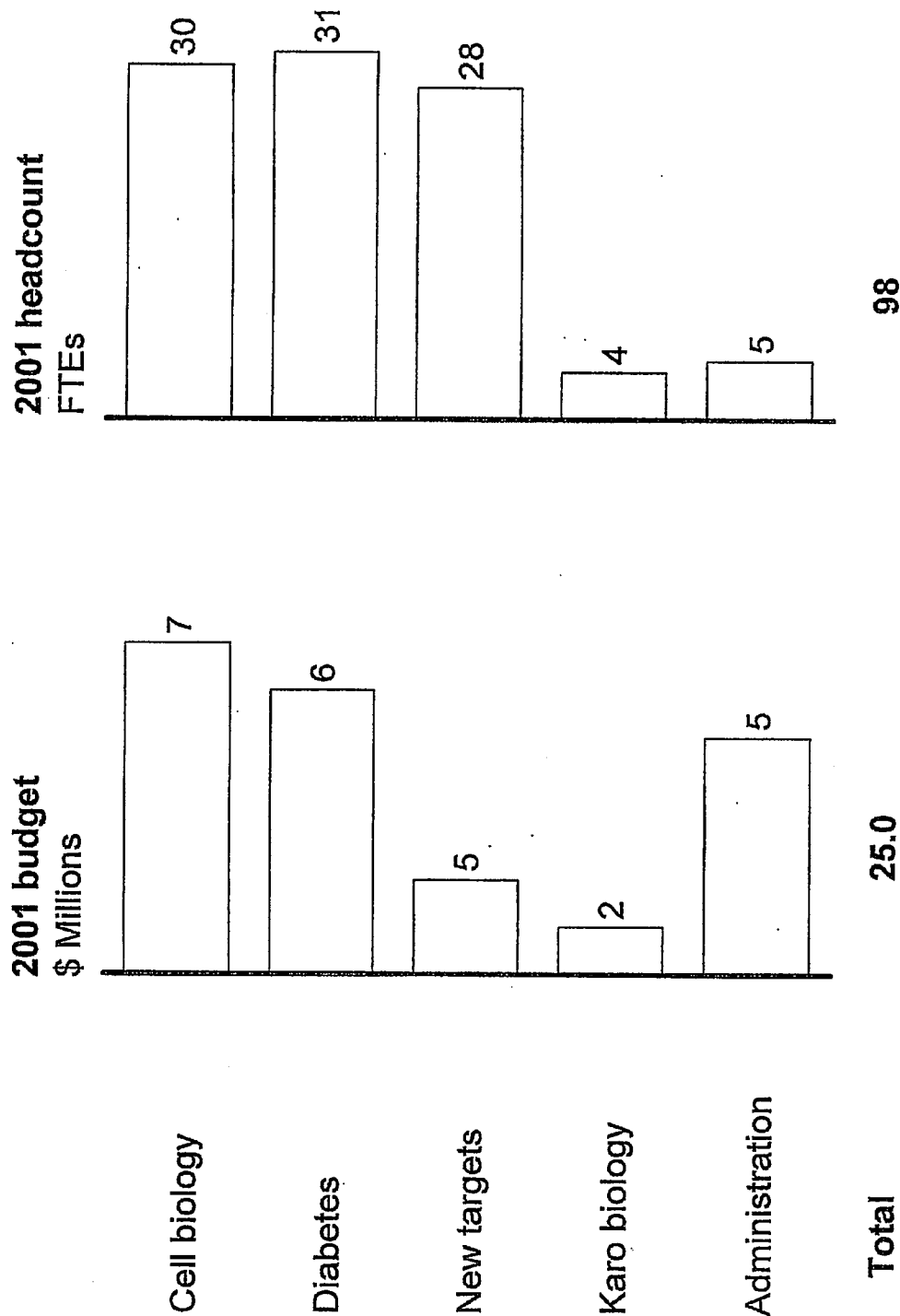
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PRELIMINARY

ABBOTT PARK DISCOVERY – MDR

\$ Millions; FTE



Source: GPRD Finance

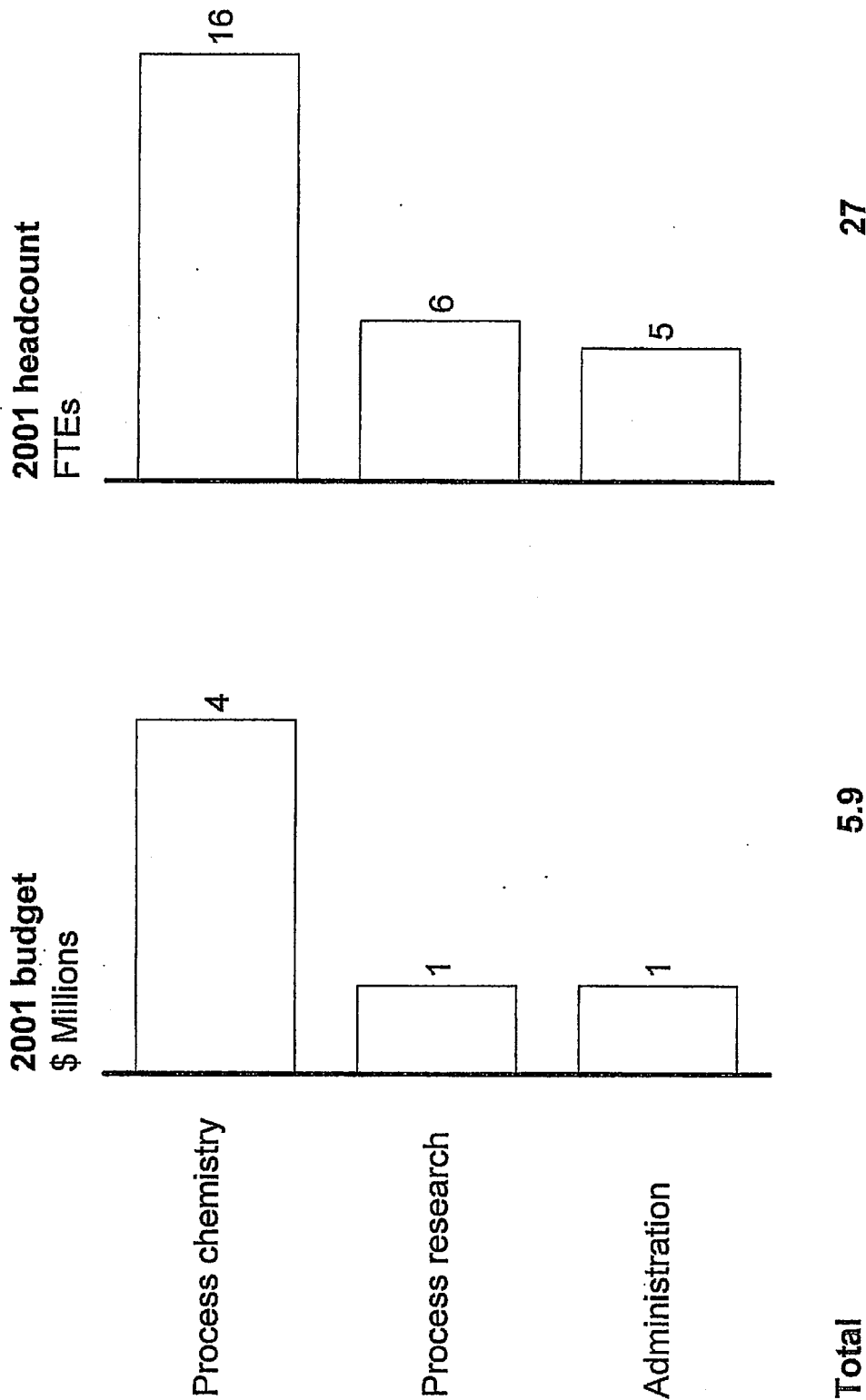
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PRELIMINARY

ABBOTT PARK DISCOVERY – CHEMICAL SCIENCES

\$ Millions; FTE



Source: GPRD Finance

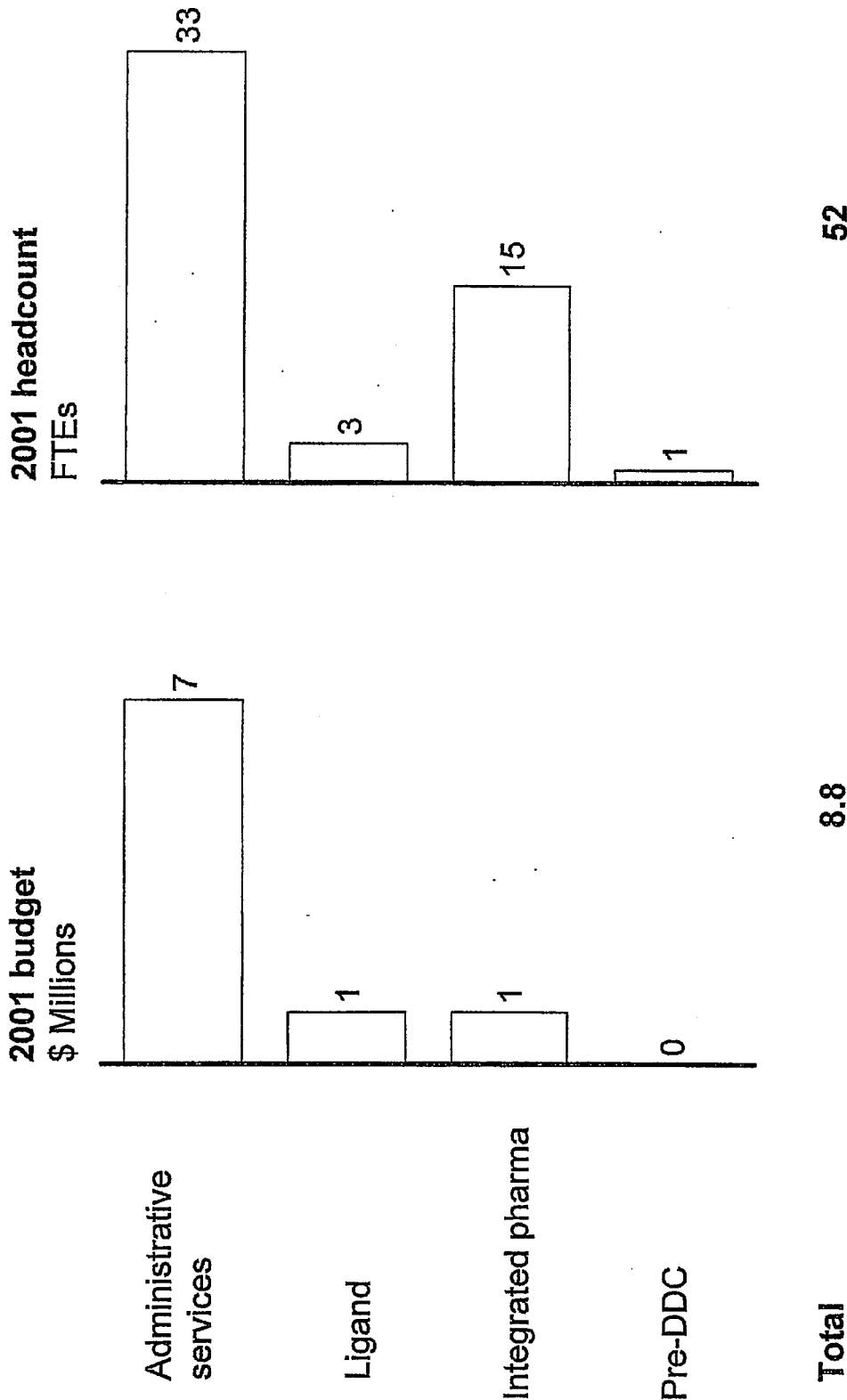
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PRELIMINARY

ABBOTT PARK DISCOVERY – ADMINISTRATION/OTHER

\$ Millions; FTE



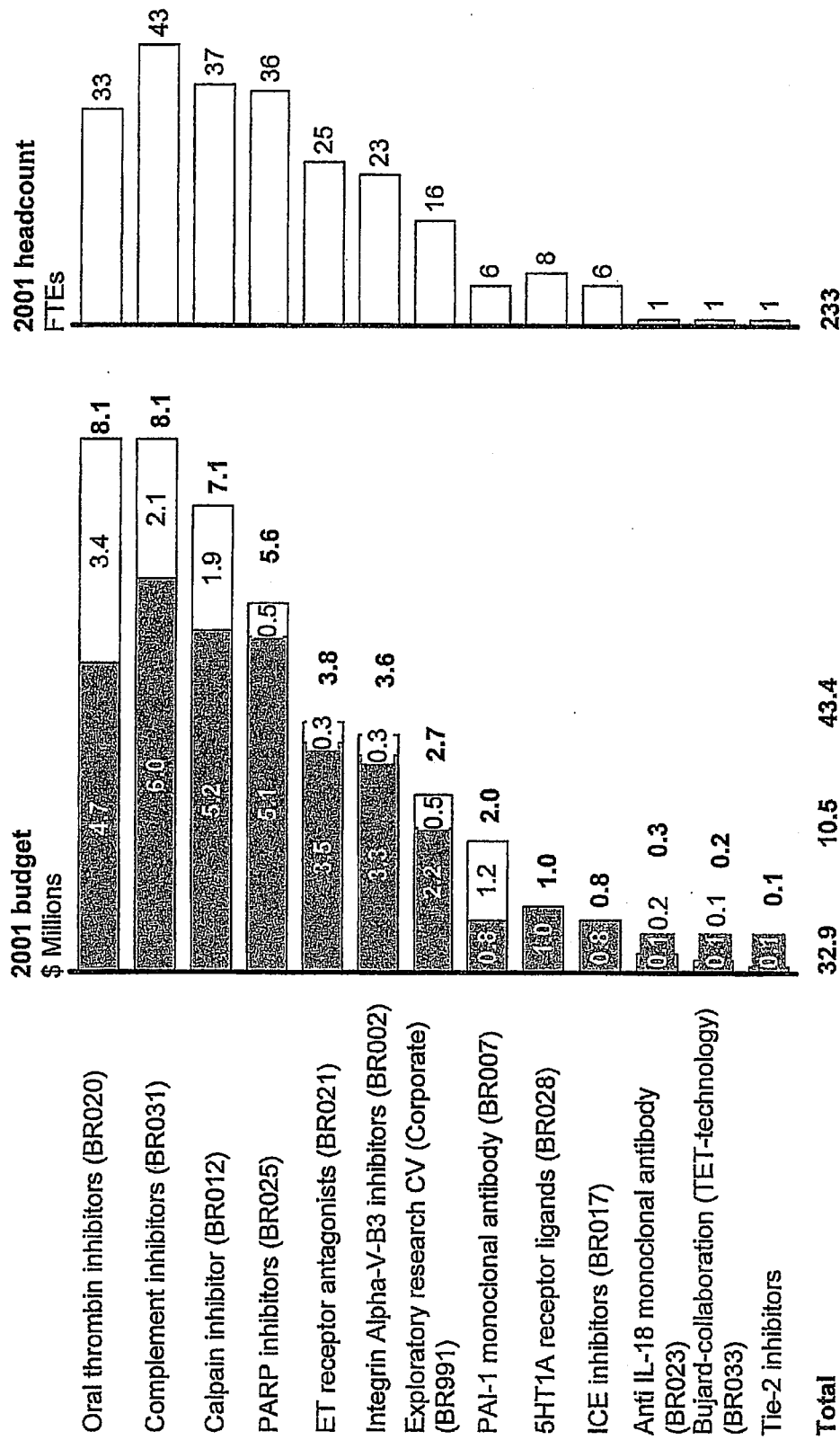
Source: GPRD Finance

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LUDWIGSHAFEN DISCOVERY**APRIL UPDATE**

Internal
External



Source: GPRD finance

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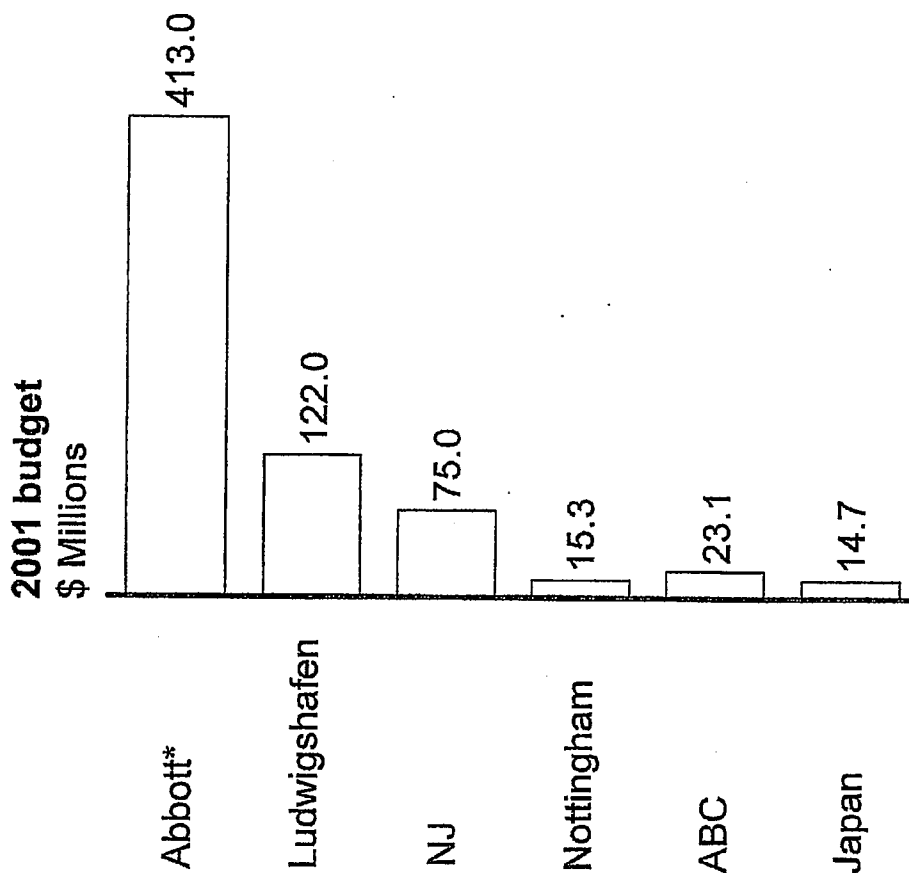
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APPROXIMATE

SUMMARY OF DEVELOPMENT RESOURCE ALLOCATION BY SITE



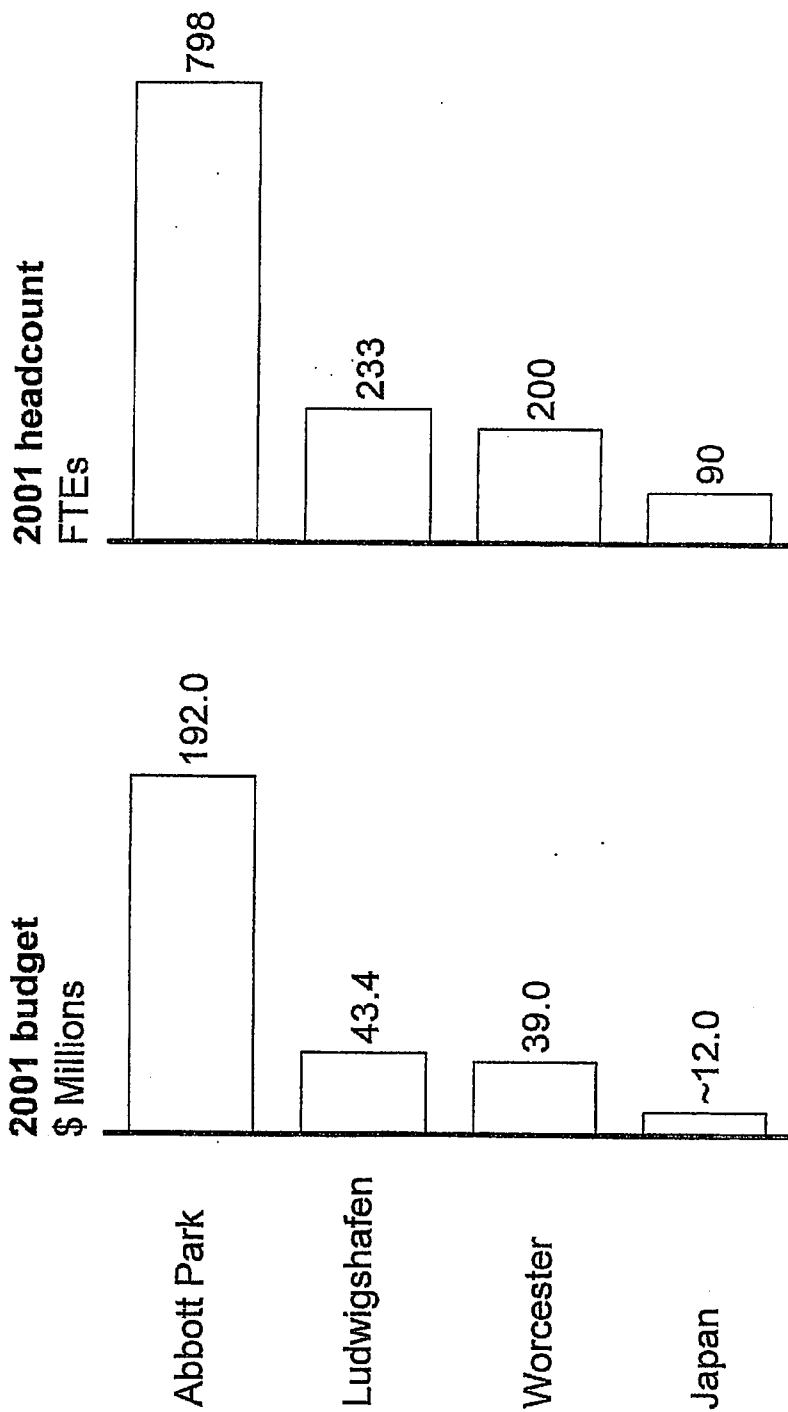
* Mostly Lake County; includes worldwide clinical trials

Source: GPRD Finance; Ludwigshafen Finance

CH-CH-228013-013j/aARD

PRELIMINARY

SUMMARY OF DISCOVERY RESOURCE ALLOCATION BY SITE



Source: GPRD Finance

CH-CH-228013-013jb/aaRD

CONTENTS

- Synergy targets and opportunities identified to date
- Potential savings by TA and project in development
- Potential savings by TA and project in discovery
- Functional area and site budgets
- Decision templates
- Appendix

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – ANTI-INFECTIVES

Project	Continue	Terminate	Next steps	Responsibility
ABT-773 (ketolide)				
Kaletra				
ABT-492 (quinolone)				
Clarithromycin				
Omnicef				
Ritonavir				

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DEVELOPMENT PROJECT DECISION TEMPLATE – IMMUNOSCIENCE

Project	Continue	Terminate	Next steps	Responsibility
D2E7				
J695				
Segard				
Gengraf				
Honkunalin tape				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – ONCOLOGY

Project	Continue	Terminate	Next steps	Responsibility
ABT-627 (endothelin)				
ABT-510 (TSP-1)				
ABT-751 (anti-mitotic)				
ABT-518 (MMPI)				

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DEVELOPMENT PROJECT DECISION TEMPLATE – CARDIOLOGY/THROMBOSIS

Project	Continue	Terminate	Next steps	Responsibility
Darusentan				
Propafenone				
Clivarine				
Fenofibrate				
Tarka				

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DEVELOPMENT PROJECT DECISION TEMPLATE – METABOLIC/DIABETES/OBESITY

Project	Continue	Terminate	Next steps	Responsibility
Sibutramine				
T4/T3				
Synthroid				

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DEVELOPMENT PROJECT DECISION TEMPLATE – PAIN

Project	Continue	Terminate	Next steps	Responsibility
Dilaudid				
ABT-594				
Hydrocodone				
ABT-963 (cox II)				
Vicoprofen				

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DEVELOPMENT PROJECT DECISION TEMPLATE – NEUROSCIENCE

Project	Continue	Terminate	Next steps	Responsibility
Depakote				
BSF 201640				
ABT-089 (ADHD)				

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE – RENAL

Project	Continue	Terminate	Next steps	Responsibility
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PEG-Hirudin

CH-CH-228013-013jb/aaRD

DEVELOPMENT PROJECT DECISION TEMPLATE -- UROLOGY

Project	Continue	Terminate	Next steps	Responsibility
ABT-598 (KCO)				
BSF 420627				

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DEVELOPMENT PROJECT DECISION TEMPLATE – GI

Project	Continue	Terminate	Next steps	Responsibility
AU 224				
Ganaton				

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CH-CH-228013-013[b]aaRD

DISCOVERY PROJECT DECISION TEMPLATE – NUDOR

Project	Continue	Terminate	Next steps	Responsibility
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Urology research

Purinergic mod.

CCM

Exploratory
urologyExploratory
neurobiology

CNS research

Chemistry

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MCK 00255

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DISCOVERY PROJECT DECISION TEMPLATE – CANCER

Project	Continue	Terminate	Next steps	Responsibility
Angiogenesis				
F-Tase				
HDAC				
Apoptosis				
Exploratory cancer				
Urokinase				
Anti-mitotic				
Biology				
Chemotherapeutics				

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DISCOVERY PROJECT DECISION TEMPLATE – INFECTIOUS DISEASE

Project	Continue	Terminate	Next steps	Responsibility
Anti-bacterial chemistry				
Anti-viral				
Anti-bacterial biology				
General microbiology				

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DISCOVERY PROJECT DECISION TEMPLATE – ADVANCED TECHNOLOGY

Project	Continue	Terminate	Next steps	Responsibility
Combinatorial chemistry				
Structural biology				
Screening				
Genomics				
Automation				
Structural chemistry				
Molecular div/ patent				

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DISCOVERY PROJECT DECISION TEMPLATE – MDR

Project	Continue	Terminate	Next steps	Responsibility
Cell biology				
Diabetes				
New targets				
Karo biology				

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DISCOVERY PROJECT DECISION TEMPLATE – CHEMICAL SCIENCES

Project	Continue	Terminate	Next steps	Responsibility
Process chemistry				
Process research				

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DISCOVERY PROJECT DECISION TEMPLATE – ADMINISTRATION/OTHER

Project	Continue	Terminate	Next steps	Responsibility
Ligand				
Integrated pharma				
Pre-DDC				

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CH-CH-228013-013/b/aaRD

SYNERGIES WITH ABBOTT'S OTHER BUSINESSES

Therapeutic area	Synergies
Anesthesia	<ul style="list-style-type: none"> • Hospital presence in OR and ICU creates opportunities for launching/ optimizing acute care cardiovascular products and for pain products • Infusion devices
Anti-infectives	<ul style="list-style-type: none"> • Genotype/phenotype monitoring with ADD
Cardiology/thrombosis	<ul style="list-style-type: none"> • Potential opportunities in drug/device combinations (e.g., drug-coated stents, thrombolysis-related devices, etc.)
Immunosciences	<ul style="list-style-type: none"> • HPD Breonics (organ preservation for transplant) • Pain franchise – OA and RA • Discovery synergy with oncology • Nutritional (e.g., CD, renal dysfunction in transplant)
Metabolic/diabetes/obesity	<ul style="list-style-type: none"> • Joint product offerings with Ross (Glucerna, Ensure) and MediSense (Precision QID, SofTac) • Co-develop new products with Ross, MediSense, ADD, and Pharmacogenetics • Bringing Tricor into franchise
Neuroscience	<ul style="list-style-type: none"> • Multiple synergies with other franchises <ul style="list-style-type: none"> – ADD: development of a diagnostic for Alzheimer's disease – Oncology: an additional channel for sales of anti-depressants – Diabetes: Potential use of H3 in obesity – Pain: synergies in molecular targets and neural systems beginning at the discovery level – Immunoscience: potential for Ab-based therapies and involvement of inflammatory mediators in neuropsychiatric diseases

Source: Strategy retreat template

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SYNERGIES WITH ABBOTT'S OTHER BUSINESSES (CONTINUED)

Therapeutic area	Synergies
Oncology	<ul style="list-style-type: none"> • Diagnostic and therapeutic antibodies • Tumor load testing • Pharmacodynamics and pharmacogenomics • Target therapy to tumor genotype
Pain	<ul style="list-style-type: none"> • Pain is associated with multiple other therapeutic areas (e.g., cancer, diabetes, neuroscience, and urology) • Discovery synergies with urology and neuroscience • Overlap with perioperative/anesthesia, acute care injectables, and animal health
Renal care	<ul style="list-style-type: none"> • Multiple combinations possible <ul style="list-style-type: none"> – Kidney disease and diabetes and diagnostics and CV – Vascular protection and CV device – ARF genomics and diagnostics and GPRD genomics – Erythropoietin and oncology
Urology	<ul style="list-style-type: none"> • Overlap of ED/FSD drugs with diabetes franchise • Overlap of urologic pain drugs with analgesia and/or any primary care franchise

Source: Strategy retreat template

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PROPOSED COMMUNICATION OF DECISIONSFOR DISCUSSION

Audience	Key messages	Vehicle	Timing	Responsibility
<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions (discovery and decisions) • Next steps 	<ul style="list-style-type: none"> • E-mail or conversation 	May 8	<ul style="list-style-type: none"> • J. Leiden
<ul style="list-style-type: none"> • R&D sub-teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing portfolio decisions • Additional second set of synergy targets 	<ul style="list-style-type: none"> • R&D Steering Committee meeting 	May 8*	<ul style="list-style-type: none"> • J. Leonard • D. Norbeck • X. Frapaise
<ul style="list-style-type: none"> • VP TAs • Venture heads, global project management 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one or group meeting 	May 8	<ul style="list-style-type: none"> • J. Leonard

* Currently scheduled for May 10 but could not be moved up to communicate decisions

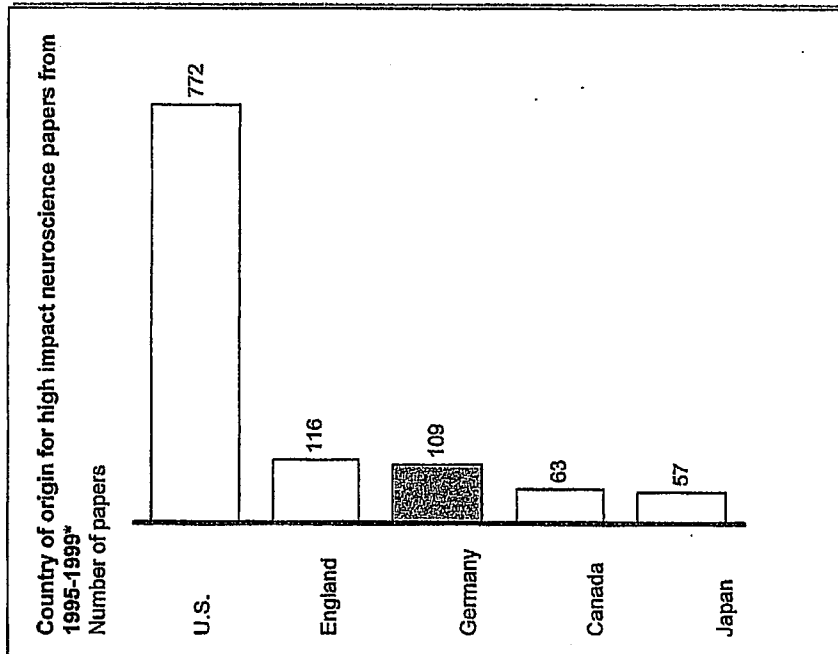
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PROPOSED COMMUNICATION OF DECISIONS (CONTINUED)FOR DISCUSSION

Audience	Key messages	Vehicle	Timing	Responsibility
<ul style="list-style-type: none"> • Venture/project teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/ implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • Venture team meetings 	By May 11	<ul style="list-style-type: none"> • Venture heads
<ul style="list-style-type: none"> • Discovery TA heads 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/ implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one or group meeting 	May 8	<ul style="list-style-type: none"> • D. Norbeck
<ul style="list-style-type: none"> • Discovery project teams 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • Project or TA team meetings 	By May 11	<ul style="list-style-type: none"> • Discovery TA heads
<ul style="list-style-type: none"> • Site leaders <ul style="list-style-type: none"> – ABC – Japan – Ludwigshafen – Mt. Olive – Nottingham 	<ul style="list-style-type: none"> • Key TAs going forward • Site decisions/implications • Portfolio decisions • Timing of implementing decisions • HR issues/implications 	<ul style="list-style-type: none"> • One-on-one conversations 	By May 11	<ul style="list-style-type: none"> • J. Leiden

CH-CH-228013-013/b/aarD

TOP NEUROSCIENCE RESEARCH CENTERSPRELIMINARY

German Institutes with most high impact neuroscience papers from 1995-1999*		
Institute	Location	Number of papers
Max Planck Institute of Psychiatry	Munich, German	14
Max Planck Institute of Medical Research	Heidelberg, Germany	11
University of Freiburg	Freiburg, Germany	8
University of Munich	Munich, Germany	6
University of Tübingen	Tübingen, Germany	6
Christian-Albrechts-University of Kiel	Kiel, Germany	5
Max Planck Institute for Brain Research	Frankfurt, Germany	4
University of Heidelberg	Heidelberg, Germany	4
Central Institute for Mental Health	Mannheim, Germany	3
Max Planck Institute for Biophysical Chemistry	Göttingen, Germany	3
Max Planck Institute for Neurobiology	Martinsried, Germany	3
Technical University of Munich	Munich, Germany	3
University of Göttingen	Göttingen, Germany	3
University of Konstanz	Konstanz, Germany	3

* The high-impact papers are determined by frequency of citation – the 200 most frequently cited papers through 2000 from each of the following years, 1995, 1996, 1997, 1998, and 1999, were then determined. The list was generated by identifying the institute affiliated with the author(s) of these papers. The neuroscience publications compiled by the Institute for Scientific Information tend to be focused more on basic science (e.g., *Nature*) than clinical science (e.g., *New England Journal of Medicine*)

Source: Institute for Scientific Information (ISI); interview with manager of contract research at ISI

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\$ Millions

APRIL UPDATE

Source: GPRD Finance

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PROJECTS BY TA (CONTINUED)
\$ Millions

APRIL UPDATE

TA	Project	2001 budget	2001 shut-down cost		
			Internal	External	Total
• Immunology	• D2E7	102.7	?	?	?
	• Gengraf	2.5	0.7	1.2	1.9
	• Hokunalin Tape	0.0	0.0	0.0	0.0
	• J695	14.0	3.6	6.6	10.2
	• SEGARD	11.9	6.0	5.9	11.9
	Total	131.1			
• Metabolic	• Sibutramine	26.0	7.5	13.9	21.4
	• T4/T3	9.3	?	?	?
	Total	35.3			
• Neurology	• ABT-089 (ADHD)	0.9	0.6	0.0	0.6
	• BSF 201640	(2.3)	0.0	0.0	0.0
	• Depakote	24.1	10.6	5.5	16.1
	Total	22.7			
• Oncology	• ABT-510 (TSP-1)	10.8	5.9	0.2	6.1
	• ABT-518 (MMP1)	7.1	4.4	0.2	4.6
	• ABT-627 (Endothelin)	38.4	12.6	2.1	14.7
	• ABT-751 (Anti-mitotic)	8.3	3.5	0.0	3.5
	Total	64.6			

Source: GPRD Finance

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PROJECTS BY TA (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget	2001 shut-down cost		
			Internal	External	Total
• Other	• Synthroid	1.7	?	?	?
	• Vicoprofen	1.2	?	?	?
	• Tarka	1.1	?	?	?
	Total	4.0			
• Pain	• ABT-594	9.3	7.7	1.1	8.8
	• ABT-963 (COX II)	1.3	1.1	0.1	1.2
	• Dilaudid	14.4	?	?	?
	• Hydrocodone	3.4	?	?	?
	Total	28.4			
• Renal	PEG-Hirudin	21.7	?	2.2	?
	Total	21.7			
• Urology	ABT-598 (kco)	5.0	1.4	0.0	1.4
	BSF 420627	4.9	?	?	?
	Total	9.9			
	Grand total	556.3			

Source: GPRD Finance

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IMPACT OF R&D SYNERGIES IDENTIFIED ON LUDWIGSHAFEN

PRELIMINARY

Function	Synergy opportunity	Cost savings		Cumulative headcount reductions in Ludwigshafen		Comments
		2001	2002	2001	2002	
CMC	• Close Ludwigshafen chemical development plant	3.9	9.3	37	37	• Achieving savings identified in 2001 is closely tied to timing of headcount reductions
	• Scale up formulation facility of Ludwigshafen	(0.3)	(5.0)	(23)	(63)	• Significant headcount additions in CMC could be key factor in Workers' Council negotiations
Data management and statistics	• Reduce development operations headcount	0.1	0.2	2	2	• Impact of current plan is likely limited
Discovery	• Close high throughput screening at Ludwigshafen	0.7	4.2	29	29	• Headcount reductions identified are more than any other function
						• Plan is to consolidate operations in Abbott Park
Drug safety	• Move contracted work in Europe to Abbott Park	1.3	1.9	—	—	• Savings dependent upon directing project teams to use internal (Abbott Park) resources
	• Reduce radiochemistry operations	0.2	0.7	5	5	
IM&T	• Eliminate non-critical IT positions	0.1	0.3	3	3	• Most savings are from disentanglement of services from BASF corporate
Medical affairs*	• Reduce health outcomes personnel	0.1	0.2	2	2	• Impact of current plan is likely limited

* Excludes initiatives related to AEGIS conversion and reductions in Phase IV trials
Source: Synergy templates; sub-team leaders; team analysis

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PRELIMINARY

IMPACT OF R&D SYNERGIES IDENTIFIED ON LUDWIGSHAFEN (CONTINUED)

Function	Synergy opportunity	Cost savings		Cumulative headcount reductions in Ludwigshafen		Comments
		2001	2002	2001	2002	
Phase 1	• Increase utilization of Ludwigshafen Phase 1 unit	0.1	0.2	—	—	• Savings dependent upon ability to control location of Phase 1 trials
	• Reduce pharmacokinetic contractor	—	0.3	—	1	
	• Reduce clinical pharmacology headcount	0.1	0.5	4	4	
	• Defer planned AQS upgrades in Ludwigshafen	0.1	—	—	—	
Regulatory affairs/QA	• Reduce head count in Ludwigshafen and operating expenses in regulatory affairs	0.1	0.3	3	3	• Current plan is to consolidate some regulatory and QA activities in Abbot Park
Venture/global team management	• Reduce head count in project management	0.2	0.5	4	4	• Impact of current plans is likely limited
Total		6.7	13.6	66	27	

Source: Synergy templates; sub-team leaders; team analysis

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HPD R&D BUDGET

\$ Millions

APRIL UPDATE

TA	Project	2001 budget
Perioperative and intensive care	• Precedex	5.7
	• PCA III	2.9
	• Corlopam	6.9
	• Rapid dissolve-RP Scherer	3.1
	• Controlled release hydrocodone	4.4
	• Long acting local/systemic anesthetic	1.0
	• Masimo	0.3
	• All other	3.7
	• Total	28.0
Renal care	• Zemplar Phase IV	0.7
	• Zemplar capsules	10.0
	• Zemplar pediatric ESRD	1.3
	• Calcijex pediatric ESRD	0.6
	• Renal care new candidates	1.4
	• Erythropoiesis product feasibility	2.6
	• Pharmacosmos – next generation IV iron	2.5
	• Pronova (Omacor)	–
	• All other	5.0
	• Total	24.1

Source: HPD finance

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HPD R&D BUDGET (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget
Oncology/anti-infective	• Na Pro Pacitaxel	-0.8
	• SuperGen – Rubitecan	–
	• Antisoma – Theragyn	7.8
	• ABT-773	–
	• All other	0.2
	• Total	7.2
Vascular	• Perclose	13.7
	• Restenosis inhibition (Biocompatibles)	1.7
	• Low molecular weight heparin delivery	1.4
	• rUK/Abbo utilization	–
	• Abbokinase	10.8
	• rUK	7.4
	• Total	34.9
Critical care	• Q2+	2.3
	• All other	1.2
	• Total	3.5

Source: HPD finance

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HPD R&D BUDGET (CONTINUED)

\$ Millions

APRIL UPDATE

TA	Project	2001 budget
EDDS	<ul style="list-style-type: none"> • Plum at therapy module • Plum at multi-channel • Gemstar • All other • Total 	1.2 4.8 1.2 - 7.3
Acute care injectables	<ul style="list-style-type: none"> • Milrinone IV • Amiodarone • Epinephrine Syringe • All other • Total 	0.2 0.1 1.4 4.8 6.5
All other	<ul style="list-style-type: none"> • Opus • Aegis • Other development • Operations support • Capitalization impact • Total R&D/medical 	1.5 0.3 17.6 45.6 -9.0 161.0

Source: HPD finance

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HOPFIELD Dep. Ex. 11 / PLs' FS



Jessica Hopfield
05/06/2001 02:42 PM

To: Patricia Weber/NJE/NorthAmerica/MCKINSEY@MCKINSEY
cc:
Subject: Please print and put in mail folder

----- Forwarded by Jessica Hopfield/NJE/NorthAmerica/MCKINSEY on 05/06/2001 02:43 PM -----



Jessica Hopfield
05/06/2001 02:41 PM

To: Jeff.leiden@abbott.com
cc: Michael Williams/NJE/NorthAmerica/MCKINSEY@MCKINSEY, David Keeling/CHI/NorthAmerica/MCKINSEY@MCKINSEY, Dick Ashley/CHI/NorthAmerica/MCKINSEY@MCKINSEY, (bcc: Jessica Hopfield/NJE/NorthAmerica/MCKINSEY)
Subject: R&D Strategy Retreat Output

Jeff,

Below are a few items from our Friday afternoon session for you to pass on as appropriate to the group. We will be working with Bob and John over the next few days to be sure they have all the costs and headcount information from the sub-teams so that the project and location roll-ups can be completed.

There are two issues I wanted to follow-up on. First is CMC where the team has made real progress over the last few weeks through workshops and has considered the issues raised on Friday (e.g., maintaining expertise, ability to move equipment) to develop a plan with significant savings. You will see this material later this month but Michael Williams can give you a sneak preview if you have concerns about where the team is.

The second issue is LU as a site for CNS. While returning the cardiology protein chemists and channel types to CNS is straightforward (and Germany certainly has a tradition in membrane biophysics), attracting true worldclass talent to LU to run the program may be tough. My background just happens to be in the area of Abbott focus (I received a PhD and was a post-doc with Torsten Wiesel and Paul Greengard at Rockefeller on protein phosphorylation of the nicotinic acetylcholine receptor and third messenger modulation of dopamine activity) and I am hard-pressed to think of hot-talent with good drug instincts willing to move to Germany. You may want to be careful about committing too large a group to the site until you have a better read on this and Jim Sullivan's willingness to travel extensively.

- Notes by TA and project with next steps - most are Jim or John to-dos.



Strategy Retreat Next Steps by Project.c

- Previous action items from the March 7-9 development review. Group already has this but many items



are pending NEXT STEPS - development portfolio prioritization

- 2001 Project-related savings identified



2001 Savings Identified.doc



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MCK 00408

- Discovery structure and headcount



Proposed Discovery Organization.d

Jessica

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MCK 00409

R&D Strategy Retreat Next Steps by TA and Project

Anti-infectives	Overall	Jim to examine Chiron HCV patent issue
		Jim to continue Pharmaset discussions (cell culture, model development)
		Bob and John to determine what to do with 6 pre-clinical headcount at LU
	Ritonavir	Bob to determine \$4 m expenditure
		John to kill all spending possible
Urology	ABT – 598	Continue until POP/clear Phase II a results are in
	BSF 420627	Still pending task force assessment
Oncology	Overall	Jim to assess acquisition of Ilex and possible development partners such as BMS
		Discovery and development to continue; Bob and Steve charged with developing revised plan to focus on anti-angiogenesis only and to push two compounds into man quickly and cheaply
	ABT – 627	Convene 1 day panel with prostate and cancer trial experts and then return to EC
	ABT – 510	Finish Phase I, do not progress to Phase II until entire program/strategy is approved
	ABT – 518	Terminate

Cardiology	Overall	Jim to assess viability of spin-out; develop asset list and portfolio list asap HPD to look at LU pig stent models in next two weeks
	Darusentan	Jim to sell – start process in next 90 days Slow all activities
	PEG-Hirudin	Will probably stop pending expert panel
Neuroscience	Overall	Jim Sullivan to recruit leader over next one to two years; start headhunting now
	ABT – 089	Dan to develop plan for accelerating
	Dilaudid	Bob to determine Phase IV activities in costs
	ABT – 594	Pending until EC review Phase II results; consider IV formulation
	ABT – 963	John to convene external panel to look at GI, Alz, and other indications Jim to continue to look for partner
	Vicoprofen	All activities not yet started to be stopped
Diabetes/Met	Overall	Need for small core team to look for external opportunities and compounds Jim to continue Novo discussions
	Sibutramine	John to appoint someone to “bulldog” studies to keep costs down Phase IV study review to be held
	T4/T3	All work to stop until program is reviewed John and Bob to evaluate how to reduce spend

GI	AU-224	Ed to complete marketing assessment
	Ganaton	John and Chris to develop plan to do inexpensively
Immunosci	Overall	Jim to work with HGS to identify targets for mAbs
		Jim to continue Genentech discussions
		Bob and Dan to develop recommendation on how to organize kinase platform
	D2E7	John to develop costs on Crohn's
	J695	Iris to work with John and Bob on spending
	Segard	Stop all U.S. work; continue Europe
Renal	Overall	Need for focused program around leveragable assets
		Analysis needed on what therapies likely to impact early and late stages of disease
		Consider bringing in expert to run program

INITIAL PORTFOLIO PRIORITIZATION

Project	Priority	Next steps	Responsibility	Timing	C- continue P- pending T- terminate
Anti-infectives					
ABT-492	C	<ul style="list-style-type: none"> • Address safety issues (including QTc) with internal/ expert review • Determine how many indications at launch (pay back) 	• J. Leonard	-	
HSR-903	T	<ul style="list-style-type: none"> • Consider trading with Daiichi • Halt any new expenditure 	• J. Tyree	-	
ABT-773	C	<ul style="list-style-type: none"> • Assess side effects issues with expert review (QTc and liver tox.) • Ensure all drug interactions are adequately covered • Assess relative to Ketek 	• J. Leonard • J. Leonard • I. Loew	-	
Urology					
BSF 420627	P	<ul style="list-style-type: none"> • Set up task force to address issues and bring back plan to senior management <ul style="list-style-type: none"> - Reasons for failure of the SKB ETa/b antagonist - Design short (~4 week) PoP trial for symptom relief - Rationale for sustained release formulation - Nature of the Schwarz Pharma relationship 	• J. Leonard	• By May	
Hypothyroidism					
T3/T4	P	<ul style="list-style-type: none"> • Assess most appropriate ratio • Gain FDA feedback on study design • Determine ex-US market attractiveness (price) 	• J. Leonard	• By May	
Asthma					
Hokunalin tape	P	<ul style="list-style-type: none"> • Conduct market research on acceptance by different patient segments • Determine how to position against long acting beta agonists and combination inhalers • Evaluate opportunity to gain complete access to the patch technology 	• A. Higgins/ E. Fiorentino • J. Tyree	• May	

0

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Oncology ABT-510	C	<ul style="list-style-type: none"> • Pursue proof of concept • Leverage TAP knowledge of angiogenesis product development (appropriate endpoints) 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • As planned
ABT-751	C	<ul style="list-style-type: none"> • Pursue proof of concept • Use echocardiogram to monitor potential cardiotoxicity • Resolve potent drug manufacturing approach 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • As planned
ABT-518	Hold	<ul style="list-style-type: none"> • Wait for May results from Pfizer (will save ~\$1mill) and re-evaluate • Halt all further expenditure 	<ul style="list-style-type: none"> • CMC group • Senior management 	<ul style="list-style-type: none"> • May
Rubitecan	P	<ul style="list-style-type: none"> • Significant clinical rework required (funded by partner)- further in-depth review required • Make a proceed decision when 2Q data available 	<ul style="list-style-type: none"> • J. Leonard 	<ul style="list-style-type: none"> • By May
Theragyn	P	<ul style="list-style-type: none"> • Negative initial scientific perspective - further in-depth review required, e.g., <ul style="list-style-type: none"> - Determine if there is a PoC to support claim - Address GMP issues - Determine best control to demonstrate efficacy • Re-look at partnership contract 	<ul style="list-style-type: none"> • J. Leonard 	<ul style="list-style-type: none"> • By May
ABT-627	C	<ul style="list-style-type: none"> • Seek alternative funding (e.g., NCI) before starting major trial • If move ahead <ul style="list-style-type: none"> - Determine how to ensure NDA filing in 2004 - Get FDA input since survival not primary endpoint - Harmonize US and EU study design and inputs • Consider partnership (e.g., BI or established oncology player) 	<ul style="list-style-type: none"> • J. Tyree • J. Leonard, P. Nisen 	<ul style="list-style-type: none"> • By May • ASAP

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Cardiology/ thrombosis Darusentan (LU 135252)	Hold	<ul style="list-style-type: none"> Continue currently budgeted funding for next 6 months Do not start any new trials (e.g., hypertension planned for May) If proceed, plan for pilot to look at effects in sperm and tetragonality Consider out-license or swap 	<ul style="list-style-type: none"> Project team J. Tyree 	<ul style="list-style-type: none"> Ongoing ASAP
LU 208075	Hold	<ul style="list-style-type: none"> Continue currently budgeted funding for next six months Look at Myogen deal Out-license or swap 	<ul style="list-style-type: none"> Project team J. Tyree 	<ul style="list-style-type: none"> ongoing
Levosimendan	C	<ul style="list-style-type: none"> Conduct detailed expert panel review for trial design 	<ul style="list-style-type: none"> J. Leonard 	<ul style="list-style-type: none"> May
PEG-hirudin	P	<ul style="list-style-type: none"> Set up expert panel for commercial assessment (is diabetes an option?) 	<ul style="list-style-type: none"> E. Ogunro 	<ul style="list-style-type: none"> By May
Ancrod	T	<ul style="list-style-type: none"> Identify out-licensing opportunities 	<ul style="list-style-type: none"> J. Tyree 	<ul style="list-style-type: none"> TBD
Urokinase	P	<ul style="list-style-type: none"> Market research required on open cath Match versus tPA in dose-ranging studies to determine efficacy 	<ul style="list-style-type: none"> E. Fiorentino 	<ul style="list-style-type: none"> By May
Pro-urokinase	C	<ul style="list-style-type: none"> Identify opportunities to speed up program 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> TBD
Clivarine	C	<ul style="list-style-type: none"> Assessment by HPD (review previous evaluation and new trial data) Understand finished product manufacturing cost 	<ul style="list-style-type: none"> E. Ogunro B. Dempsey 	<ul style="list-style-type: none"> By May
Rythmol SR	C	<ul style="list-style-type: none"> Continue filing Verify if package is likely approvable Assess commercial attractiveness in a generic market 	<ul style="list-style-type: none"> Project team 	<ul style="list-style-type: none"> Ongoing

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Neuroscience ABT 594	P	<ul style="list-style-type: none"> • Await results from ongoing PII trial – probable T • Project team to develop decision criteria for go/no go 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • June/ July
ABT 963	C	<ul style="list-style-type: none"> • Identify a co-development/co-promotion partner (TAP high on list) • Evaluate benefits of the long half life in pain and cancer (including additional physician market research) • Explore cancer prophylaxis and Alzheimer's indications 	<ul style="list-style-type: none"> • J. Tyree • Project team 	<ul style="list-style-type: none"> • TBD
BSF 201640	P	<ul style="list-style-type: none"> • Complete review of all schizophrenia NCEs with expert panel • Complete staffing of internal project team, but halt further expenditure beyond looking at hepatic tox. and QTc • Understand Novartis contract and level of interest 	<ul style="list-style-type: none"> • I. Loew • Project team 	<ul style="list-style-type: none"> • By May
BSF 190555	P	<ul style="list-style-type: none"> • Complete review as above • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • J. Tyree • I. Loew 	<ul style="list-style-type: none"> • As above
BSF 74398	C	<ul style="list-style-type: none"> • Allow DevCo to continue development • Re-look at relationship with DevCo 	<ul style="list-style-type: none"> • Project team • J. Tyree 	<ul style="list-style-type: none"> • By May
Diluadid Oros	Hold	<ul style="list-style-type: none"> • Return to ALZA or out-license to other interested partner 	<ul style="list-style-type: none"> • J. Tyree 	<ul style="list-style-type: none"> • TBD
Hydrocodone	C	<ul style="list-style-type: none"> • Assess regulatory pathway • Understand DEA impact on manufacturing 	<ul style="list-style-type: none"> • Project team 	<ul style="list-style-type: none"> • By May
Bimoclomol (ABT 822)	P	<ul style="list-style-type: none"> • Await data from ongoing trial in April before deciding whether to continue - probable T • Halt further expenditure pending outcome 	<ul style="list-style-type: none"> • Senior management 	<ul style="list-style-type: none"> • April

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Gastro-enterology Ganaton	P	<ul style="list-style-type: none"> • Conduct U.S. commercial assessment with TAP • Assess how to position in Europe versus generics and implications for comparative trial • Develop model to assess spend at different termination points 	• E. Fiorentino	• By June
	T	<ul style="list-style-type: none"> • Terminate outside Japan 	• Bob Funck	• By May
	C	<ul style="list-style-type: none"> • Develop and pursue a small PoC trial in humans ASAP (consider niche indication first and leverage Marlene's expertise) • Conduct market research on IBS versus constipation (including pricing) 	<ul style="list-style-type: none"> • Project team • Project team • E. Fiorentino 	<ul style="list-style-type: none"> • Immediate • ASAP
Immunology D2E7	C	<ul style="list-style-type: none"> • Conduct intensive product review <ul style="list-style-type: none"> - 2 day meeting with J. Lennard's group (already in process) - ½ day session with senior management group • Important actions include <ul style="list-style-type: none"> - Approach FDA for fast track and compassionate use - Develop strategy for DIMARD claim in first submission - Assess need for Enbrel assay to detect HAHAs - Assess delivery device options - Evaluate additional indications (e.g., Psoriasis, Crohns, heart failure) and pediatric program - Profile Celltech product - Assess impact of additional IV program on reimbursement • Develop list of potential marketing partners for quids 	<ul style="list-style-type: none"> • J. Leonard • Various • J. Tyree 	<ul style="list-style-type: none"> • By May • By May

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
Immunology (continued) Segard	Hold	<ul style="list-style-type: none"> • Continue filing in EU and Canada • Put on hold in US – consider creating a small team in the US to analyse data, propose smaller PII study • Research pricing, marketing and Phase IV plans in Europe • Look at TNF-alpha levels retrospectively to see stratification with IL-6 • Assess manufacturing strategy • Identify potential out-licensing opportunities (Genentech) 	<ul style="list-style-type: none"> • Project team • J. Leonard 	<ul style="list-style-type: none"> • Ongoing
J695	P	<ul style="list-style-type: none"> • Decide on most attractive indications from Abbott and partner perspective • Discuss with partner ways to share the various indications and potential for TNF-alpha combinations • Add commercial person to the project team by this week 	<ul style="list-style-type: none"> • J. Tyree • E. Fiorentino • J. Tyree • Ongoing 	<ul style="list-style-type: none"> • ASAP

INITIAL PORTFOLIO PRIORITIZATION (CONTINUED)

C- continue
P- pending
T- terminate

Project	Priority	Next steps	Responsibility	Timing
PIV programs				
Clarithromycin	C	• None identified	-	-
Omnicef	C	• Talk to partners	• J. Tyree	-
Kaletra	C	• None identified	-	-
Norvir	C	• None identified	-	-
Meridia	Hold	• Conduct commercial assessment for CNS and depression (P&L)	• B. Dempsey, J. Arnott, E. Florentino	• ASAP
		• Assess combination therapy with fibrates	• Project team	
		• Assess outcomes trial design to meet preferred commercial profile; determine payback		
Uprima	C	• Ensure no redundant trials with TAP in Europe	• Project team	• Ongoing
Trandolapril patch	T	• Halt all activities	• Project team	• Immediate
Trandolapril "Invest" clinical program	P	• Review trial in more detail (reduce complexity and risk)	• E. Fiorentino	• By May
Other trandolapril trials	C	• Continue "Create", "Peace" and "Benedict" trial programs	• Project team	• Ongoing
Fenofibrate	C	• Develop co-formulation ideas with Meridia and statins (including assessment of sales and costs)	• Project team	-
Depakote	C	• None identified	-	-
Gengraf	C	• None identified	-	-

2001 Savings Identified (\$ millions)

Ritonivir	4.0
ABT - 518	2.5
LU 135252	8.5
PEG - Hirudin	11.2
Dilaudid	14.0 (needs further assessment)
Vicoprofen	.9
Sibutramine	4.6 (needs further assessment)

Additional opportunities in:

HPD Pharma

Dex

Levo

Proposed Discovery Organization

1. Neuroscience	400
• Pain – US based	
• Psych – LU based	
2. Diabetes/metabolism	125
3. Anti-infectives	125
• novel rib	
• pump inhibitor	
• HCV instead of HIV	
4. Immunoscience	200
• mAb platform	
• RA (large and small molecule)	
• kinases	
5. Oncology	200

Note: headcount numbers include Japan but do not include HPD

2001 Savings Identified (\$ millions)

Ritonivir	4.0
ABT - 518	2.5
LU 135252	8.5
PEG - Hirudin	11.2
Dilaudid	14.0 (needs further assessment)
Vicoprofen	.9
Sibutramine	4.6 (needs further assessment)

Additional opportunities in:

HPD Pharma

Dex

Levo

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MCK 00422

THOMAS WOIDAT
Abbott Manager
Financial Planning & Analysis

JOHN HANCOCK'S DEPOSITION DESIGNATIONS

THOMAS WOIDAT
Abbott Manager,
Manager, Financial Planning and Analysis
July 20, 2004

FROM	TO	Exhibit
p. 8, l. 21	p. 9, l. 5	None
p. 9, l. 21	p. 10, l. 8	None
p. 29, l. 19	p. 29, l. 24	None
p. 33, l. 24	p. 35, l. 16	None
p. 91, l. 9	p. 91, l. 23	Dep. Ex. 1/ PLs' LW Dep. Ex. 2/ PLs' MB
p. 95, l. 22	p. 96, l. 11	Dep. Ex. 2/ PLs' MB
p. 97, l. 1	p. 97, l. 6	Dep. Ex. 2/ PLs' MB
p. 110, l. 113	p. 111, l. 9	Dep. Ex. 3/ PLs' RX
p. 116, l. 16	p. 117, l. 4	Dep. Ex. 3/ PLs' RX
p. 151, l. 12	p. 152, l. 7	Dep. Ex. 2/ PLs' MB Dep. Ex. 3/ PLs' RX
p. 160, l. 12	p. 161, l. 6	Dep. Ex. 5/ PLs' IV
p. 171, l. 11	p. 171, l. 24	Dep. Ex. 2/ PLs' MB Dep. Ex. 4/ Ex. 33
p. 188, l. 6	p. 188, l. 24	Dep. Ex. 10/ PLs' RY
p. 191, l. 12	p. 191, l. 19	Dep. Ex. 10/ PLs' RY
p. 199, l. 1	p. 200, l. 2	Dep. Ex. 4/ Ex. 33
p. 202, l. 2	p. 202, l. 21	Dep. Ex. 11/ PLs' IZ
p. 204, l. 11	p. 204, l. 22	Dep. Ex. 11/ PLs' IZ

00001

1 UNITED STATES DISTRICT COURT
2 FOR THE DISTRICT OF MASSACHUSETTS
3
4 JOHN HANCOCK LIFE INSURANCE)
5 COMPANY, JOHN HANCOCK VARIABLE)
6 LIFE INSURANCE COMPANY, and)
7 MANULIFE INSURANCE COMPANY)
8 (f/k/a INVESTORS PARTNER)
9 INSURANCE COMPANY),)
10 Plaintiffs,)
11 vs.) Civil Action
12 ABBOTT LABORATORIES,) No. 05-11150-DPW
13 Defendant.)

14 The videotaped deposition of **THOMAS**
15 **EDWARD WOIDAT**, called for examination, taken
16 pursuant to the Federal Rules of Civil Procedure
17 of the United States District Courts pertaining to
18 the taking of depositions, taken before **NANCY A.**
19 **GUIDOLIN**, CSR No. 84-2531, a Notary Public within
20 and for the County of DuPage, State of Illinois,
21 and a Certified Shorthand Reporter of said state,
22 at Suite 1300, 2 North LaSalle Street, Chicago,
23 Illinois, on the 10th day of April, A.D. 2007, at
24 9:23 a.m.

00003

21 THE VIDEOGRAPHER: Will the reporter now
22 swear in the witness, please.
23 (WHEREUPON, the witness was duly

24 sworn.)

00004

1 THOMAS EDWARD WOIDAT,
2 called as a witness herein, having been first duly
3 sworn, was examined and testified as follows:

4 EXAMINATION

00008

21 Q. And what is your current position with
22 Abbott Labs?

23 A. The title of my current position is
24 senior manager global financial operations.

00009

1 Q. And what division of Abbott Labs is
2 that in?

3 A. It is in the division of global
4 pharmaceutical research and development, which I
5 may refer to -- the acronym is GPRD.

00009

21 Q. Before that position what was your role
22 at Abbott?

23 A. My role was -- I was in the same
24 division, GPRD. I believe my title was manager of

00010

1 financial planning and analysis.

2 Q. And how long were you in that position?

3 A. Actually, I was in that position --
4 actually, I got promoted and some of my
5 responsibilities changed a little bit, but
6 essentially about six years.

7 Q. So from about '98 to 2004?

8 A. Correct.

00029

19 Q. And I assume ordinarily actual spending
20 wouldn't change, right? You have -- at a certain
21 point in time if you have determined actual
22 spending up through today, a month from now
23 spending up through today wouldn't have changed?

24 A. Correct.

00033

24 Q. Are you familiar with the reference to

00034

1 nominal versus expected spending?

2 A. Yes. I am.

3 Q. And what do you understand the
4 difference, if any, between nominal and expected
5 spending?

6 A. Well, it's a -- it's a fairly common
7 finance term, I think, but in the context of GPRD
8 nominal would reflect the related spend
9 independent of risk, and expected would reflect
10 risk considerations associated with the activities
11 to which the R&D spend relates.

12 Q. So typically nominal spending would be
13 greater than expected spending, would it not?

14 A. Correct. Under the assumption that --
15 yes.

16 Q. All right. I mean, it could be the
17 same if there is little or no risk?

18 A. Right. If there is no -- if there is
19 no risk, it could -- absolutely it could be the
20 same.

21 Q. But assuming there is usually some risk
22 involved, there're likely that they are going to
23 be different, and nominal would be in excess of
24 expected?

00035

1 A. Correct.

2 Q. For purposes of Abbott's budget cycle
3 that we talked about previously, the annual plan
4 and then the two updates, does Abbott use nominal
5 spending numbers or expected spending numbers?

6 MS. GUZELSU: Objection.

7 BY MS. COLLARI TROAKE:

8 Q. If you know.

9 A. We typically use nominal budgets, but
10 in terms of evaluating the commercial return, for
11 example, of a given compound, again, this would be
12 inclusive of not just the R&D stream, but further
13 down stream in terms of eventual sales and
14 profits. Risk and unexpected value might be part
15 of the analysis leading to the decision to approve
16 budgets.

00091

9 Q. And the 2001 Plan is about 9.3 million,
10 right?

11 A. Yes.

12 Q. And as you understand this schedule,

13 spreadsheet, the 2001 Plan number, that 9.3
14 million, would that include all of the spending,
15 not just clinical grants?

16 A. That would be my inference, yes.

17 Q. But either you or someone in your team
18 would have been responsible for creating this
19 Excel spreadsheet, would they not?

20 A. Yes.

21 Q. And it would have been subject to the
22 vetting for reasonableness and review for
23 accuracy, would it not?

24 A. Yes.

00095

22 Q. So if you look down under the
23 antiinfective, the second item is Ketolide, which,
24 correct me if I am wrong, is the same as 773,

00096

1 right?

2 A. You are correct. Yes.

3 Q. And under "Corporate Submission" there
4 it requests 91, I believe, million, right?

5 A. Yes.

6 Q. And under the "2001 Final Plan" it's 88
7 million?

8 A. Yes.

9 Q. And so they basically asked for 91, but
10 only 88 was approved, correct?

11 A. Yes.

00097

1 Q. And, again, here we have a number under
2 "Corporate Submission" which is about 7 million?

3 A. Yes.

4 Q. But 7.4 was actually approved in the
5 2001 Plan, right?

6 A. Yes.

00110

13 (WHEREUPON, a certain document was
14 marked Woidat Deposition Exhibit
15 No. 3, for identification, as of
16 4-10-07.)

17 BY MS. COLLARI TROAKE:

18 Q. Mr. Woidat, I have put in front of you
19 what has been marked as Woidat Exhibit 3. If you
20 could take a moment to look at that and let me
21 know whether you recognize that document.

22 A. I am sorry. What was the question?

23 Q. Do you recognize that document?

24 A. I do.

00111

1 Q. And what is that?

2 A. Excuse me?

3 Q. What is it?

4 A. It's a communication from myself to
5 other members of our GPRD finance team regarding
6 some comments on the finalization, or I shouldn't
7 say finalization, but development of the April
8 update budgets for various programs as attached
9 here.

00116

16 Q. Then the 2001 Plan number, the 2001 APU
17 and the 2001 APU revised all state the same 9.3
18 million, correct?

19 A. Yes.

20 Q. So does this indicate, then, that you
21 weren't proposing any kind of adjustment to the
22 plan spending for 594 for 2001?

23 A. It would appear not.

24 Q. That you were not proposing any

00117

1 adjustment?

2 A. No. I think that the proposed
3 adjustments were in the third column here, and
4 there is not any for 594.

00151

12 Q. And if you look at -- you probably want
13 to keep Exhibit 2 open, but could you also grab
14 Exhibit 3, please, which is your e-mail with your
15 adjustments, proposed April update target
16 adjustments.

17 A. Okay.

22 A. Okay.

23 Q. Okay. The schedule that you have here
24 for 773 says, "2001 Plan 88, 2001 update 88."

00152

1 There is a proposed adjustment for 1.6, but that
2 only gets us to 89.6, correct?

3 A. Correct.

4 Q. Which, again, is different from what is
5 in the March 13th agreement given to Hancock of
6 91.5?

7 A. Right.

00160

12 (WHEREUPON, a certain document was
13 marked Woidat Deposition Exhibit
14 No. 5, for identification, as of
15 4-10-07.)

16 BY MS. COLLARI TROAKE:

17 Q. Mr. Woidat, I have put in front of you
18 what has been marked as Exhibit 5. If you can
19 take a moment -- there's a couple of different
20 components of Exhibit 5. If you could take a look
21 at it and let me know whether you recognize all or
22 any of Exhibit 5, please.

23 A. I am sorry. What was the question on
24 this one?

00161

1 Q. Do you recognize any or all of
2 Exhibit 5?

3 A. I recognize this (indicating).

4 Q. "This" being the e-mails, which is the
5 first part of Exhibit 5?

6 A. Yes.

00171

11 Q. So as of the data in Exhibit 2,
12 February 16, 2001, Abbott's 2001 Plan reviewed for

13 reasonableness is saying 9.1 -- 9.3 million for
14 ABT-594 for 2001, right?

15 A. Yes.

16 Q. Okay. And the agreement, Exhibit 4,
17 dated March 13, 2001, about a month later is
18 indicating almost four times that, 35 million,
19 right?

20 A. Yes.

00188

12 Q. Mr. Woidat, I have put in front of you
13 what has been marked as Exhibit 10. Can you let
14 me know whether you recognize that document, and
15 it is actually three separate spreadsheets, and
16 they are just stapled together for my convenience.
17 They weren't produced in that way.

18 A. Okay.

19 Q. Do you recognize those?

20 A. No. I mean, they appear to be
21 develop -- development cost summaries for ABT-594
22 for various benchmarks, but I don't -- I don't
23 recall anything specifically about these
24 documents. I may have seen them. I don't know.

00191

12 Q. Do you have any understanding as to why
13 this Development Cost Summary, the April update
14 about a month after the agreement is signed,
15 doesn't reflect the 35 million in the Development
16 Cost Summary that was provided to John Hancock?

17 MS. GUZELSU: Objection.

18 BY THE WITNESS:

19 A. I don't.

00199

1 Q. But the document attached to Exhibit 4
2 that we are talking about, the one to your right,
3 about that 594 is a document provided by Abbott
4 Labs in relation to the agreement. It indicates
5 on its face that Abbott is planning on spending
6 for 2001 with respect to 594 a total of 35
7 million, correct? The total on the page says, "35
8 million," right?

9 A. Yes, yes.

10 Q. Okay. Your March 21st e-mail dated a
11 week after this agreement has no indication
12 anywhere near 35 million spending for ABT-594,
13 right?

14 MS. GUZELSU: Objection. 26 million? Oh,
15 you mean total spending?

16 MS. COLLARI TROAKE: Total 35 million.

17 MS. GUZELSU: Okay. I am sorry.

18 BY THE WITNESS:

19 A. So my -- I am sorry. So my e-mail has
20 the --

21 BY MS. COLLARI TROAKE:

22 Q. Your e-mail has 2001 final plan numbers
23 and 2001 April update numbers and proposed
24 adjustments, right, and for 594 it's 9.3 with no

00200

1 proposed adjustments?

2 A. 9.3, yes.

00202

2 (WHEREUPON, a certain document was
3 marked Woidat Deposition Exhibit
4 No. 11, for identification, as of
5 4-10-07.)

6 BY MS. COLLARI TROAKE:

7 Q. I am going to give you what has been
8 marked as Exhibit 11.

9 A. Okay.

10 Q. Let me know whether you recognize that
11 document, please?

12 A. Okay. This appears to be a
13 communication between myself and Jenny Dart
14 exchanging some information relating to -- I am
15 assuming the 2001 update budget assumptions.

16 Q. Okay. And do you recognize the
17 attachments, the two charts attached to the
18 e-mail?

19 A. No. But it appears to be some
20 information that Jenny and her colleagues in the
21 portfolio analysis were tracking or analyzing.

00204

11 Q. And if you go to the right and the
12 second to the last column which is headed "2001
13 Plan," it says, "9.3 million," right?

14 A. Okay. I am sorry. The second -- 2001.
15 Yes. I see that.

16 Q. Okay. It doesn't say 35 million,

17 right?

18 A. No. It says, "9.3."

19 Q. And this is April 12, 2001. So roughly

20 a month after the Hancock agreement was signed

21 it's still saying 9.3 million for 594, right?

22 A. Yes.

Woidat Dep. Ex. 1/ PLs' LW

-NOV. 20, 2003 8:23AM

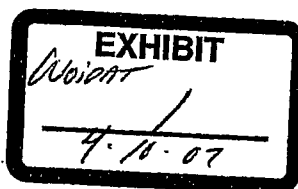
NO. 1275 P. 20

ANALGESIA VENTURE**2001 PLAN****Revised 1/26/01**

To:

John Leonard.
Chris Silber
George Carter
Bruce McCarthy
Mike Blamases
Steve Cohen
Mike Higgins
Mike Comilla
Matt Russell
Tom Woidat
Barbara Massa
Marleen Verlinden

Highly Confidential



ABBT0503356

NOV. 20. 2003 8:23AM

NO. 1275 P. 21

**Analgesia Venture
2001 PLAN Review (Pass II)
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1	Summary of Projects
2	ABT-594 Key Statistics
3	ABT-594 Grants
4-5	ABT-594 Project Expense
6	ABT-089 Key Statistics
7	ABT-089 Grants
8	ABT-089 Project Expense
9	NPS 1776 Key Statistics
10	NPS 1776 Grants
11	NPS 1776 Project Expense
12	ABS-103 Key Statistics
13	ABS-103 Grants
14	ABS-103 Project Expense
15	ABT-963 Key Statistics
16	ABT-963 Grants
17	ABT-963 Project Expense
18	Venture Functional Expense
19	Blue Plan Summary

NOV. 20. 2003 8:24AM

NO. 1275 P. 22

T

**Analgesia Venture
Summary
2001 PLAN Pass II**

	2001 Target	2000 AGU	2001 PLAN	Target vs PLAN Fav(Unfav) Var
ABT-594	8,900	14,411	9,307	(407) a
ABT-089	"	3,000	613	(613) b
NPS 1776	"	"	537	(537) c
ABS-103	"	"	"	" b
ABT-963	"	4,000	1,186	(1,186) b
Venture Total	8,900	21,411	11,643	(2,743)

a Includes a \$120,000 charge from SFD not in Oracle

b Completion of work started in 2000, bringing it to a logical holding position.

c Includes a \$490,000 charge from SFD included in Oracle in error.

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NO. 1275 P. 23

Analgesia Venture
ABT-594
2001 PLAN KEY STATISTICS Page II
(\$000)

(\$000)						
	2001		2002		2003	
	Target	AGU	PLAN	AGU	PLAN	Target vs PLAN Fav(Unfav) Var
Enroll	8,900	14,411	9,307			(407)
Neurokinin receptor antagonist (Milestones Funded to Go/No Go June, 2001)						
Key Milestones/Assumptions						
• IND Filing			Completed			
• Initiate Phase II - U.S.			Completed			
• Go/No Go Clinical Efficacy (Phase IIa)			Completed			
• Go/No Go Clinical Efficacy (Phase IIb)			Completed			
• Initiate Phase III - U.S.			Completed			
• File NDA U.S./EMEA EU			Completed			
PEARL						
• Analytics Dev & Support			Completed			
• Formulation Dev & Support			Completed			
• Clinical Planning			Completed			
• Project Management Support			Completed			
• PARC Total			Completed			
2001 AGU 2,409 2002 AGU 2,409 2003 AGU 2,409						
2001 PLAN 1,075 2002 PLAN 1,075 2003 PLAN 1,075						
Analysis F, Support Milestones Chart & Process Justification						
Formulation scale-up and process optimization						
Completion of N99-116, Paving 3 P's study supplies						
Coordination of activities and support of go/no go meeting prep						
2001 AGU 2,409 2002 AGU 2,409 2003 AGU 2,409						
2001 PLAN 1,075 2002 PLAN 1,075 2003 PLAN 1,075						
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Study	EUSN	2000 AGU					2001 PLAN					2001 PLAN TOTAL AGU PAYMENT
		Start	End	Total	Index	Cost	Start	End	Total	Index	Cost	
Program Phase II	6/98-4/01											(165,000)
Human Metabolism III												(100,000)
POU/Pancreatic pain model												(100,000)
Treatment Optimization												(100,000)
Phase IIb												(100,000)
Neurospinal Pain (Oxyphid)	8/98-1/01											(100,000)
Phase III												(100,000)
Chronic Postoperative Pain												(100,000)
Back and Hip Pain Studies												(100,000)
Adjustment												(100,000)
Back and Hip Pain Studies												(100,000)
TOTAL												(1,000,000)

Analgesia Yellere
CLINICAL GRANTS
ABT-394
2001 PLAN Phase II

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ABBT0503360

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NO. 1275 P. 25

PHARMACEUTICAL PRODUCTS RESEARCH AND DEVELOPMENT
2000 AUGUST UPDATE / 2001 PLAN
G0-143010 CCM ABT594 (BASE & ORAL PAIN)

	(\$000)				
	2000	2000	FAV/(UNFAV) AUG. UPD VS. APR. UPD.	2001 PLAN	FAV/(UNFAV) PLAN VS. AUG. UPD.
	APU	AGU			
26-Jan-01					
4:04 PM					
PPD INVESTIGATIONAL DR					
PPD Investigational Drug QA	23	55	(32)	86	(32)
	23	55	(32)	86	(32)
Venture Management					
Analgesia/CCM Venture	4,739	4,493	246	3,988	505
	4,739	4,493	246	3,988	505
Discovery					
Advanced Technology	25	50	(25)	26	24
Neurological & Urological Res	---	---	---	51	(51)
	25	50	(25)	77	(28)
Drug Safety					
Experimental Science	23	70	(46)	187	(118)
Clinical Drug Analysis	290	290	---	409	(120)
Toxicology	1,366	896	471	233	663
Pathology	604	572	32	493	79
Comparative Medicine	591	591	---	34	557
Strategic & Exploratory Science	4	---	4	7	(7)
	2,877	2,417	460	1,362	1,055
Pharm Analytical R&D					
ANALYTICS DEV & SUPPORT	791	879	(88)	641	238
FORMULATION DEV & SUPPORT	764	745	19	226	519
CLINICAL FINISHING	403	607	(204)	145	462
PROJECT MGMT SUPPORT	197	178	20	63	115
	2,155	2,409	(254)	1,075	1,334
PHASE-I CENTER					
Phase-I Admin/Pharmacokinetics	185	185	---	259	(74)
ACPRU	23	25	(2)	367	(343)
	208	210	(2)	627	(417)
Development Operations					
Data Management	475	475	---	259	216
Statistics	160	171	(11)	129	42
ABBOTT RES & LIBRARY INF-ARL	89	89	---	140	(51)
	724	735	(11)	528	207
Regulatory Affairs					
Regulatory Affairs	20	20	---	151	(131)
Research QA	131	80	50	82	(1)
	151	100	50	232	(132)
Medical Affairs					
Genetics/Admin	---	---	---	2	(2)
Medical Services	53	53	---	10	43
Outcomes Res./Admin.	42	42	---	37	5
	95	95	---	49	46
Administration					
R&D Operations/Project Services	75	43	32	45	(2)
	75	43	32	45	(2)
AI MANPOWER					
International Manpower	50	20	30	53	(33)

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NO. 1275 P. 26

2000 AUGUST UPDATE / 2001 PLAN
G0-143010 CCM ART594 (BASE & ORAL PAIN)

26-Jan-01
4:04 PM

PPD R&D SERVICES PURCH
SPD Services Purchased

CLINICAL GRANTS
CLINICAL GRANTS

(S000)			FAV/(UNFAV) AUG. UPD VS. APR. UPD.	2001 PLAN	FAV/(UNFAV) PLAN VS. AUG. UPD.
2000 APU	2000 AGU				
50	20		30	53	(33)
235	235				235
235	235				235
3,000	2,800		200	1,065	1,735
3,000	2,800		200	1,065	1,735
14,357	13,661		696	2,187	4,474

SPD

120
9,307

Friday, January 26, 2001 4:04:48 PM


PROJECT GLOBAL PPD REPORT BY PROJ SUBDIV

Page 2 of 4

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Woidat Dep. Ex. 2/ PLs' MB

 **Abbott Laboratories**
Interoffice Correspondence

From: Matt Russell
PPD R&D Finance
D-404, AP9 Ext. 5-3482
Date: March 2, 2001

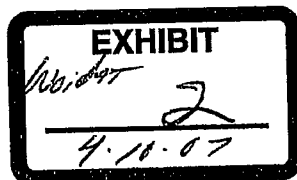
TO:	Bob Funck	D-404 AP9	Mike Higgins	D-404 AP9
	Tom Woidat	D-404 AP9	Mike Comilla	D-404 AP9
	Kirnes Holland	D-404 AP9	Paula Bourland	D-404 AP9
	Mischelle Vidakovic	D-404 AP9		

Subject: 2001 PLAN FINAL Reference Package

Attached you will find a copy of the 2001 PLAN FINAL Reference Package. This package has consolidated many of the key schedules we used in the PLAN. Hopefully, this will make referencing numbers from the PLAN easier for everyone. Please let me know if you have any questions.

HIGHLY

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ABBT 0037509



2001 PLAN

FINAL Reference Package

Data as of February 16, 2001

**HIGHLY
CONFIDENTIAL
ABBT 0037510**

2001 PLAN Reference Package

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HIGHLY
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FINAL OpCost

HIGHLY
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ABBT 0037512

2001 PLAN
Pharmaceutical Products Research & Development
Operating Cost Statement
(\$000)

	2000 ACTUALS	09/25/00 FINAL DO AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/31/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	01 PLAN VS DO AGU
Pharmaceutical Discovery	134,725	134,088	145,324	--	(4,648)	(4,648)	140,636	(5,948)
-New Technology (sect 742-505)	17,430	19,160	10,814	--	(4,458)	(4,458)	12,446	3,714
Total Pharmaceutical Discovery	152,153	150,848	162,238	--	(9,106)	(9,106)	153,062	(2,224)
Drug Safety Evaluation	7,541	8,289	10,128	--	(1,507)	(1,507)	6,619	330
-Experimental Science	--	670	1,640	--	(1,012)	(1,012)	628	342
-Drug Safety Grants	5,768	5,693	5,588	--	(459)	(459)	5,129	564
-Clinical Drug Analysis	--	671	365	--	(185)	(185)	200	471
-Drug Safety Grants	5,821	7,950	7,209	--	(740)	(740)	6,469	1,481
-Toxicology	--	3,511	2,188	--	(102)	(102)	1,488	2,029
-Drug Safety Grants	3,817	3,901	3,997	--	127	127	3,724	177
-Pharmacology	--	605	--	--	220	220	220	385
-Drug Safety Grants	11,132	10,963	11,219	--	(197)	(197)	11,022	111
-Comparative Medicine	880	915	894	--	(87)	(87)	807	88
-Admin & Strategic	3,377	3,423	3,787	--	(345)	(345)	3,442	(17)
-Strategic & Experimental Science	39,176	41,134	42,520	--	(3,200)	(3,200)	39,312	1,862
Total Drug Safety Evaluation	4,181	4,819	5,645	--	(2,700)	(2,700)	2,942	1,777
Medical Affairs	6,998	6,075	7,454	--	(50)	(50)	7,398	(58)
-General/Admn	--	--	--	--	--	--	--	--
-Medical Services	1,430	1,354	1,543	--	201	201	1,743	(313)
-Clinical Pharm	8,201	5,137	6,045	--	61	61	6,706	(1,505)
-Outcomes Res/Admn	--	--	--	--	--	--	--	--
-Phase IV	20,788	18,789	21,280	--	(2,497)	(2,497)	18,789	2,000
Total Medical Affairs	1,654	2,025	2,471	--	(7)	(7)	2,464	(19)
Information Mgmt & Technology	44,502	44,763	48,529	--	(1,484)	(1,484)	47,045	7,718
-Resource Management	--	--	--	--	--	--	--	--
-Client Management	--	--	--	--	--	--	--	--
-Technology Management	718	558	840	--	--	--	840	(122)
-Emerging Tech Mgt	--	--	--	--	--	--	--	--
-I M & T Admin	40,871	47,376	51,640	--	(1,491)	(1,491)	50,249	1,127
Total Information Mgmt & Technology	8,404	8,529	10,467	--	(3,358)	(3,358)	7,119	1,310
Development Operations	8,009	8,077	8,026	--	(1,999)	(1,999)	6,436	1,643
-Data Management	3,053	3,243	3,807	--	(556)	(556)	3,251	792
-Statistics	10,566	10,849	22,320	--	(5,514)	(5,514)	16,806	4,043
-Abbott Res & Lib Info Svcs-ARUS	55	172	122	--	(122)	(122)	--	172
Total Development Operations	5,763	5,381	9,439	--	(707)	(707)	8,732	(3,697)
Venue Management	13,597	9,491	10,203	--	262	262	10,465	(1,074)
-Cardiovascular/Diabetes (CD)	2,372	2,347	3,334	--	2,414	2,414	5,748	(3,376)
-Anti - Infective	2,829	2,600	3,750	--	(1,726)	(1,726)	2,021	808
-Anti - Viral	2,839	3,102	--	--	--	--	--	2,839
-Analgesia/CCM	--	--	--	--	--	--	--	--
-Urology	6,450	6,555	6,574	--	810	810	7,364	(914)
-Molecular Therapeutics	33,726	29,708	33,422	--	928	928	34,350	(624)
-Neuroscience/Colonies	16,853	18,312	20,312	--	(680)	(680)	19,632	1,681
-Oncology & Transplant (Cancer Mgmt)	62,454	63,142	62,721	--	(3,868)	(3,868)	58,853	3,591
Total Venue	9,119	9,008	10,070	--	(648)	(648)	9,422	(403)
Administration	8,990	8,585	14,068	--	(4,398)	(4,398)	9,670	1,085
Pharm Analytical R&D	409,706	408,751	440,787	--	(30,512)	(30,512)	410,285	9,501
Regulatory Affairs	3,560	3,988	6,567	--	(2,402)	(2,402)	4,105	1,483
Phase-I Center	103,780	109,231	139,785	--	(26,467)	(26,467)	118,028	9,203
Total Functional	--	(840)	--	--	--	--	--	--
bstl - Margower	103,780	106,385	139,785	--	(9,827)	(9,827)	118,028	8,357
Clinical Grants	52,599	57,834	63,226	--	(5,127)	(5,127)	47,272	10,562
-Domestic	54,981	61,821	63,467	--	(4,322)	(4,322)	52,435	12,446
-Adjustment	--	--	8,100	--	(8,100)	(8,100)	--	8,100
Total Clinical Grants	52,599	57,834	63,226	--	(5,127)	(5,127)	47,272	10,562
Services Purchased	54,981	61,821	63,467	--	(4,322)	(4,322)	52,435	12,446
SPD Purchases	--	--	--	--	--	--	--	--
Corporate Tax	--	(10,900)	(27,894)	--	20,977	33,954	5,060	18,884
Judgment - Internal	--	(2,642)	(30,100)	--	5,000	15,300	20,300	(8,000)
Judgment - Published	--	--	--	--	--	--	--	--
Gabril reimbursement from Comenent	--	--	--	--	--	--	--	--
Hand Post/Flash to Actual Adjustments	--	--	--	--	--	--	--	--
Other Project Changes:	--	--	--	--	--	--	--	--
Total Project Changes (For Exp Cat)	--	--	--	--	--	--	--	--
Total Gross Expense	624,836	626,307	663,948	--	(14,189)	(20,374)	643,563	21,273
Services Sold	(248,043)	(251,577)	(253,811)	--	(2,411)	12,304	(244,018)	4,565
Net Total	376,793	374,730	410,137	--	(16,500)	(8,070)	399,545	(24,815)
Target:	376,793	374,730	410,137	--	(16,500)	(8,070)	399,545	(24,815)

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2001 PLAN
Pharmaceutical Products Research & Development
Services Purchased
(\$000)

	2000 ACTUALS	09/25/00 FINAL DO AGU	Book I ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	2001 PLAN	01 PLAN VS DO AGU
Patents & Trademark	5,504	5,509	5,978	74		74	6,050	(485)
Sale/Re Copy Charges	556	555	549	(10)		(10)	539	18
Corp Admin Fixed	4,890	4,995	5,126	102	217	319	5,445	(450)
Corp Cost Pools	5,031	5,175	5,231	(102)	(58)	(161)	5,070	105
CHMD Services Purchased Fixed (AHD)	193	197	197	(1)		(1)	196	1
PPD Ops Fixed Allocations	2,807	2,522	2,232				3,232	(710)
CENG - Fixed Maintenance from PPD Ops	949	947	899				899	49
CHEN Variable (EWRG)	323	141	147				147	18
CMIS - Purchasing	897	897	733	14		14	747	150
CHMS Telecommunications	110	116	110	2	12	14	130	(20)
Fixed L.C. Exp - Admin Services	415	410	427	(1)	(5)	(5)	421	(11)
Corp Eng EHS Fixed Allocation	559	558	597				597	(39)
TOTAL CORPORATE ALLOCATION	21,869	21,878	23,230	78	165	243	23,473	1,695
CMIS - Unit of Activity, Fixed - Other	3,012	2,383	3,981	(747)	(447)	(1,194)	2,867	(404)
CMIS - Unit of Activity, Fixed - Aegis	2,082	2,890	2,100				2,100	790
PPD Personnel DGA47	2,512	2,456	2,900		1	1	2,801	(145)
PPD Mfg Ops - Allocation	60	60	60	3		3	63	(3)
PPD Ops QA Int Svcs/Reg Affairs	1,438	1,438	1,842				1,842	(404)
PPD Ops Returned Goods	130	131	136				136	(6)
Project Expense (\$1MM)	10,815	11,208	11,209	(814)	(3,495)	(4,109)	7,099	(1,010)
TOTAL BURDEN FEE	41,898	42,324	45,137	(1,280)	(3,776)	(5,056)	40,081	2,249
SPD Pilot Plant Stock Card	20,928	20,960	21,195	4,632	(1,330)	3,302	24,497	(3,571)
SPD Bulk Direct	24,005	33,881	32,902	(12,674)	(2,090)	(15,064)	17,838	10,154
Excess Capacity Stock Card	9,160	9,280	9,280	2,932	(902)	2,330	11,610	(2,330)
Subtotal SPD (Other than TAP)	54,991	63,921	63,467	(5,110)	(4,922)	(10,032)	53,435	10,456
Grant/Out of Pocket Purchases:								
TAP Bulk Drug (D-TAP)	47	125	125	(41)		(41)	84	(37)
TAP - SPD Manpower & Bulk (D-453)	211	450	450	(205)		(205)	245	(205)
Pharmacogenetics - ADD Allocation								
Misc Expense								
Subtotal (For Exp Cat)	328	675	675	(246)		(246)	329	(41)
Other Purchases:								
Chel Once-A-Day (Global AI Manpower)	10,189	11,383	11,977	2	(3,916)	(3,914)	7,763	3,930
Corp Drug User Fees	1,918	1,951	1,838	(831)		(831)	1,207	744
Patent to Operations (search services)	200	200						200
D-AS4 Floor Space (not in functional)	377	405			182	182	182	223
D-AS4 Deprec (not in functional)	(501)	1,864	3,033		(49)	(49)	2,984	(1,120)
Molecular Probes	(9)	7	7				7	(16)
Inventory Transfer for Protease 2nd Gen		(5,728)						5,728
SDG/Other	877	8,287	8,000	(5,000)		(5,000)		8,287
Clinical Supplies (Trio Gen - PPD Ops)	5	200	200				200	
Angis Charges	220							220
Library (D441) to CHMS							1,500	
QA (D44N) to Operations	1,307	1,440	1,500					1,307
Sangstat (Cytokine)		(2,400)	(380)		360	380		2,400
Sangstat (Sangcyte)		867						867
Gabril Royalty								
Ritonavir/Retro Combo								
NOVO Settlement	(1,500)	(1,500)						1,500
Metabolex	(888)	(888)						888
FLAP/Vanguard	(818)	(818)						818
Sano's Cost Sharing w/Gabril		(150)						150
CI charge from OPS (Cin Val Mgr) + \$49		171						(171)
Contract Management System	47							47
HPD R&D Purchased	411							411
Yale Univ. - Survivor Patent	2							2
Staples Rebatas	(68)							68
Triangle receipt \$2,935 + \$325 for 1999	(3,482)	(2,914)	(5,381)				(5,381)	2,467
Serendite License								
Comdisco	2,440	2,440						2,440
Hydrocodone (IDV-In from HPD)				4,028	(4,028)			
CRO Rebates	(381)			(3,000)		(3,000)	(3,000)	3,000
Gabril Reimbursement from Commed					1,400	1,400	1,400	(1,400)
Other	38							38
Subtotal (For Exp Cat)	10,473	14,935	17,514	(4,601)	(6,051)	(10,652)	5,862	5,073
Grand Total	107,580	121,755	126,593	(11,237)	(14,749)	(25,986)	100,707	21,048

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2001 PLAN
Pharmaceutical Products Research & Development
Services Sold
(\$000)

02/19/01
02/29/01

	2000 ACTUALS	09/25/00 FINAL DO AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	2001 PLAN	01 PLAN VS. DO AGU
General Benefit	183,768	183,768	183,857	4,813	(12,000)	(7,187)	186,670	(2,902)
-Global Pharmaceutical								
Direct Sister Benefit	3,519	4,478	2,571	55	(242)	(167)	2,384	(2,094)
-R&D Scl Serv.	4,125	3,794	3,975	(175)	---	(175)	3,800	(8)
-Direct Service	7,744	8,272	5,546	(120)	(242)	(362)	6,184	(2,058)
Total Direct Support								
Total Int'l Sister Div.	191,512	192,040	200,403	4,693	(12,242)	(7,549)	192,854	(842)
TAP Judgment (Positive Controls)								
TAP Bulk Drug (D-TAP)	17	125	125	(41)	---	(41)	84	(41)
TAP - SPD Manpower & Bulk	211	450	450	(205)	---	(205)	245	(205)
TAP - All Other	20,715	23,359	20,170	(575)	261	(314)	19,856	(1,859)
Total TAP (incl. Judgment)	20,943	23,934	20,745	(821)	261	(560)	20,185	(3,758)
Domestic Sister Divisions:								
HPD	9,442	10,575	9,689	(950)	95	(855)	8,834	(1,608)
ADD	2,268	1,896	2,340	43	---	43	2,383	(487)
SPD	4,312	4,884	4,810	(719)	818	99	4,909	(725)
ROSS	186	663	1,851	40	64	104	1,955	(1,269)
CPD	3	39	42	---	---	---	42	(39)
MIS	69	71	69	5	---	5	74	(5)
AHD	---	---	---	---	---	---	---	---
CHMS Library Services	---	---	---	---	---	---	---	---
Corp. Eng.	20	2	---	---	---	---	---	---
Subtotal	16,300	17,930	18,801	(1,581)	977	(604)	18,197	(1,103)
Other Sister Divisions:								
Corp. Admin.								
-Corp. Admin.	71	42	23	1	---	1	24	(47)
-Tap Rate Diff	461	461	485	---	---	---	485	(24)
-Symposium Expense	165	155	155	---	---	---	155	(10)
Subtotal CHAD	687	658	673	1	---	---	674	(16)
PPD Product R&D:								
Mfg Support (MC, PM)	14,283	10,780	12,096	119	---	119	12,215	(1,435)
Mfg Support (PV)	124	285	283	---	---	---	283	(2)
PPD Marketing (PS, PE)	4,658	5,414	4,820	---	(1,300)	(1,300)	3,520	(1,138)
Subtotal Other	19,065	16,479	17,279	119	(1,300)	(1,181)	16,098	(2,381)
VAT Refund	537	537	---	---	---	---	---	---
PARD Services Sold Impact (Judgment)	---	---	(3,990)	---	---	---	(3,990)	---
Rounding	(1)	(1)	---	---	---	---	---	---
Grand Total	249,043	251,577	253,911	2,411	(12,304)	(9,893)	244,018	7,559

Memo:

INPUT Global AI from DetRoll file	N/A	183,768	183,857	N/A	N/A	N/A	186,670	
Calculated above	N/A	183,768	183,857	N/A	N/A	N/A	186,670	
Key Check (s/b D)	N/A	---	---	N/A	N/A	N/A	---	
INPUT From J:\Drive File	N/A	210,626	219,877	N/A	N/A	N/A	211,725	
Calculated above	N/A	210,626	219,877	N/A	N/A	N/A	211,725	
Key Check (s/b D)	N/A	(2)	---	N/A	N/A	N/A	---	
Sister Division Amount								
INPUT From DetRoll file	N/A	67,809	64,044	N/A	N/A	N/A	61,338	
Calculated above	N/A	67,809	60,054	N/A	N/A	N/A	57,348	
Key Check (s/b D)	N/A	---	3,990	N/A	N/A	N/A	3,990	
Sister Division Reconciliation								
Sister Division Memos -Oracle	N/A	67,809	60,054	N/A	N/A	N/A	57,348	
BP - Blue Plans	N/A	49,144	57,354	N/A	N/A	N/A	104,224	
DC - Div Computing/Systems	N/A	13,730	13,850	N/A	N/A	N/A	20,079	
DO - Department Overhead	N/A	50	50	N/A	N/A	N/A	50	
GO - Global Delivery	N/A	328,237	345,312	N/A	N/A	N/A	299,564	
GD - Global Discovery	N/A	96,719	90,107	N/A	N/A	N/A	94,827	
PI - Pharmaceutical Products	N/A	44,693	59,654	N/A	N/A	N/A	38,962	
TG - Triangle	N/A	3,071	5,401	N/A	N/A	N/A	5,481	
TAP Pass Thru & Bulk Drug not in Orac	N/A	---	---	N/A	N/A	N/A	---	
Other Judgement	N/A	---	---	N/A	N/A	N/A	3,990	
Total	N/A	603,393	631,842	N/A	N/A	N/A	624,505	
INPUT Total Per Oracle	N/A	600,093	631,253	N/A	N/A	N/A	624,471	
Variance	N/A	3,300	589	N/A	N/A	N/A	24	

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2001 PLAN
Pharmaceutical Products Research & Development
Clinical Grants
(\$000's)

02/19/01
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	2000 ACTUALS	09/25/00 FINAL 00 AGU	Book 1 ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	2001 PLAN VS. 2000 AGU
PPD SERVICE:								
Tiagabine/Gabitril	(80)	2,600	1,900	...	(1,900)	(1,900)	...	2,600
Omnicef	...	...	4,800	(2,000)	200	(1,800)	3,000	(3,000)
Depakote/Depakene	15,319	14,589	11,174	...	(1,733)	(1,733)	9,441	5,138
r-Pro-UK	(45)	(45)	...	...	...	...	...	(45)
Fenofibrate (Fournier)	799	(160)	2,250	...	(2,211)	(2,211)	39	(199)
Hematin	407	...	...	...	600	600	600	(600)
PharmacoGenetics (Genset)	...	200	200	...	...	...	200	...
TOTAL PPD SERVICE	16,400	17,184	20,324	(2,000)	(5,044)	(7,044)	13,280	2,904
GLOBAL SERVICE:								
Ritonavir ABT-538	2,715	4,382	1,752	...	(508)	(508)	1,244	2,128
Protease 2nd Gen ABT-378	30,884	30,362	13,379	...	9,196	9,196	22,575	7,377
Dopamine	...	...	...	...	380	380	380	(380)
KCO ABT-598	...	...	...	...	356	(12,695)	1,065	7,751
ABT-594 (formerly CCM)	2,106	2,800	13,760	(13,051)	(1,628)	(1,628)	...	...
ABT-089 (formerly ChCM)	...	...	1,628	...	(1,270)	(1,270)	2,940	(1,628)
Clarithromycin	2,314	4,448	4,210	...	...	...	...	...
Ketolide ABT-773	23,093	23,137	46,382	...	1,023	1,023	47,405	(24,268)
Prokinetic Macrolide - Dom	...	...	...	...	...	...	...	...
Zileuton & 2nd Generation	...	...	...	...	...	...	...	...
BPH ABT-980	13,855	14,058	16,678	(11,415)	(5,262)	(16,678)	993	11,958
Cyclosporine	7,831	7,560	1,300	...	(307)	(307)	...	...
H2G (Medivir)	63	...	...	...	...	...	...	...
Endothelin	2,066	2,440	8,794	...	10,457	10,457	19,251	(16,811)
NS 49 Nippon Shinyakkyu ABT-23	357	633	...	...	...	...	...	...
Bimacromol (Biorex)	...	...	...	...	...	...	...	...
Anti-Mitotic ABT-751	...	...	2,091	...	(1,066)	(1,066)	1,025	(1,025)
Hytrin	...	...	...	...	...	...	...	...
FTI (Farnesyltransferase)	...	...	...	...	...	...	...	...
MMPI (Metalloprotease)	116	231	1,346	...	(228)	(228)	1,118	(657)
Taxane	...	...	...	...	...	...	...	...
TSP Peptide	843	968	1,710	...	(89)	(89)	1,621	(633)
Quinolone	680	638	5,000	...	...	...	5,000	(4,662)
Cox II	157	131	784	...	(653)	(653)	131	...
Neuraminidase	123	...	...	...	...	...	...	...
Adjustment (EVR)	...	(846)	...	...	...	...	...	...
TOTAL GLOBAL SERVICE	87,203	90,942	118,814	(24,467)	10,401	(14,066)	104,748	(43,806)
MISC:								
Vitamin D Analog/Iron Dextran	...	76	...	...	...	...	...	...
Isotretinoin/Norvir Investigation	...	...	...	...	...	...	...	...
Adjustments	...	...	...	...	...	...	...	...
Dexmedetomidine/Zemplar (HPD)	177	183	647	...	(647)	(647)	...	...
Tranxene Reformulation	...	...	...	...	...	...	...	...
Blaxin Reformulation	...	...	...	...	...	...	...	...
	177	259	647	...	(647)	(647)
GRAND TOTAL GRANTS	103,780	108,385	139,785	(26,467)	4,710	(21,757)	118,028	(9,643)

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2001 PLAN
Pharmaceutical Products Research & Development
Operating Cost Statement
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02/18/01
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	2000 ACTUALS	09/25/00 FINAL 00 AGU	Book I ORACLE 2001 PLAN	10/24/2000 PRIOR ADJS	12/01/00-1/30/00 CURRENT ADJS	TOTAL ADJS	FINAL 2001 PLAN	01/18/01 VS 12/00 AGU
SDG/Other	877	1,500	3,000	(3,000)		(3,000)	---	1,500
HIV/Kno/QD/Other	---	1,000	---	---		---	---	1,000
Aegle Insurance	---	952	---	---		---	---	952
Genset #1	---	500	---	---		---	---	500
IT Productivity Projects	---	---	2,000	(2,000)		(2,000)	---	---
Neurosearch FTE \$2530, depr \$20	---	---	---	---		---	---	---
Coactinon	---	---	---	---		---	---	---
SPD IDV Liponavir	---	607	---	---		---	---	607
Triangle R&D	---	---	---	---		---	---	---
Data Management Absorbtion	---	1,078	---	---		---	---	1,078
Other New Products	---	2,650	---	---		---	---	2,650
Quinolone In License Payment	---	---	---	---		---	---	---
Division Task	---	---	---	---		---	---	---
HPD R&D Purchased	---	---	---	---		---	---	---
Total SDG/Other	877	8,287	5,000	(5,000)		(5,000)		8,287

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PPRD FUNCTIONAL EXPENSE
RECONCILIATIONS MONTH - \$
2001 PLAN

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Discovery Deals * (742-505)	12,440	---	625	2,015	250	625	2,015	250	625	2,015	250	625	3,151	12,440
All Other Discovery *	140,038	11,461	11,461	11,507	11,527	11,575	11,614	11,614	11,662	12,018	12,036	12,056	11,785	140,038
Subtotal Pharmaceutical Discovery	152,082	11,461	12,108	13,522	11,777	12,200	13,629	11,864	12,587	14,033	12,288	12,681	14,936	152,082
DRUG SAFETY														
Experimental Science	8,819	689	687	714	715	718	732	733	734	721	722	723	723	8,819
Drug Safety Grants (742-200)	628	52	52	52	52	52	52	52	52	53	53	53	53	628
Clinical Drug Analysis	5,129	423	423	424	425	425	431	432	432	428	428	428	429	5,129
Drug Safety Grants	200	17	17	17	17	17	17	17	17	16	16	16	16	200
Toxicology	4,488	524	525	537	537	538	544	545	546	542	543	544	544	4,488
Drug Safety Grants	1,488	124	124	124	124	124	124	124	124	124	124	124	122	1,488
Pathology	3,724	299	300	307	307	308	319	320	320	310	311	311	312	3,724
Drug Safety Grants	220	18	18	18	18	18	18	18	18	19	19	19	19	220
Comparative Medicine	11,022	918	918	917	917	918	918	919	919	920	920	921	921	11,022
Admin & Strategic	937	75	75	75	75	75	75	76	76	76	76	76	77	937
Strategic & Exploratory Science	3,442	264	264	265	265	265	290	290	291	287	287	288	288	3,442
Subtotal Drug Safety	30,312	3,210	3,220	3,259	3,281	3,285	3,308	3,315	3,318	3,284	3,287	3,282	3,282	30,312
MEDICAL AFFAIRS														
Administration (Cln Res - CNS)	2,842	226	227	227	247	248	255	255	256	250	250	251	250	2,842
Medical Services	7,398	598	601	612	614	617	618	620	621	623	624	625	627	7,398
Outcomes Research	1,743	124	124	138	139	139	153	153	154	154	154	155	150	1,743
Phase IV	6,706	497	626	546	556	557	567	573	575	576	577	578	578	6,706
Subtotal Medical Affairs	18,709	1,443	1,478	1,523	1,550	1,561	1,583	1,601	1,605	1,603	1,605	1,609	1,611	18,709
Information Mgmt & Technology														
Resource Management	2,404	203	204	204	205	205	205	208	207	207	207	208	203	2,404
Client Management	47,045	3,578	3,571	3,472	3,351	3,518	3,433	3,784	3,973	3,542	4,554	4,492	6,229	47,045
Technology Management	840	69	69	69	69	70	70	70	70	70	71	71	71	840
IM & T Admin	50,349	3,848	3,594	3,745	3,620	3,793	3,708	4,060	3,950	3,919	4,832	4,771	6,503	50,349
Subtotal Information Mgmt & Tech	50,349	3,848	3,594	3,745	3,620	3,793	3,708	4,060	3,950	3,919	4,832	4,771	6,503	50,349
Development Operations														
Data Management	7,118	588	589	590	591	592	593	594	595	596	597	597	597	7,118
Statistics	6,436	525	526	527	528	530	530	541	542	543	544	545	548	6,436
Abbott Res & Lib Info Eval-ARLUS	3,251	266	266	266	268	248	249	256	256	257	257	248	426	3,251
Subtotal Development Operations	16,805	1,379	1,381	1,383	1,387	1,371	1,388	1,391	1,393	1,396	1,399	1,399	1,569	16,805
VENTURE MANAGEMENT														
Cardiovascular/Diabetes (CD)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Anti-Infective	8,732	453	457	468	478	480	481	482	482	484	485	486	485	8,732
Anti-Viral	10,485	807	808	809	870	871	872	873	873	874	875	876	877	10,485
Anaesthesia/GCM	5,746	494	495	499	499	500	501	501	450	451	451	451	452	5,746
Urology	2,021	167	167	167	168	168	168	168	168	169	169	170	170	2,021
Molecular Therapeutics	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Neuroscience	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Oncology	7,384	517	518	519	594	617	623	623	623	631	632	632	636	7,384
Subtotal Venture	34,350	2,558	2,579	2,582	2,610	2,638	2,674	2,653	2,653	2,699	2,612	2,615	2,619	34,350
Administration														
PARO	18,052	1,629	1,629	1,631	1,633	1,635	1,637	1,639	1,641	1,643	1,645	1,647	1,640	18,052
Regulatory Affairs	58,053	4,890	4,891	4,967	4,939	4,971	5,045	4,991	5,042	4,992	5,059	5,045	4,931	58,053
Phase-I Center	8,422	673	699	768	788	788	800	811	812	814	815	817	831	8,422
Phase-I Center	9,670	784	772	777	812	813	815	816	817	819	820	821	824	9,670
TOTAL FUNCTIONAL	410,285	31,852	32,339	34,155	32,367	33,043	34,598	33,141	36,769	35,112	34,259	34,688	37,862	410,285
International Manpower														
Clinical Grants	4,105	287	389	205	287	308	240	452	452	452	431	411	444	4,105
Clinical Grants	118,028	8,273	8,232	10,185	10,459	10,620	11,500	8,804	10,011	10,016	9,787	10,768	10,848	118,028
QAS4 Services Purchased														
Corporate Task	100,707	9,076	9,076	8,268	8,742	8,252	8,907	8,252	8,252	8,113	8,717	8,717	8,337	100,707
Judgment - Internal	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Judgment - Published	8,060	5,668	2,809	1,944	1,289	2,250	4,725	(1,565)	(3,054)	(2,135)	599	(1,393)	(5,227)	8,060
Global reimbursement from Comm	(9,800)	(917)	(917)	(917)	(917)	(917)	(917)	(917)	(917)	(919)	(919)	(915)	(915)	(9,800)
Hand Post/Flash to Actual Adjustment	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Other Project Changes:														
Gross PPD R&D Expense	629,385	54,379	52,107	53,840	52,324	53,763	57,165	49,267	52,413	50,742	50,077	52,383	50,846	629,385
QAS5 Services Sold	(244,018)	(21,165)	(20,215)	(20,854)	(20,328)	(20,715)	(21,963)	(19,061)	(20,005)	(18,708)	(19,579)	(20,455)	(19,977)	(244,018)
Net PPD R&D Expense	385,367	33,173	31,892	33,006	31,998	33,048	35,202	30,206	31,408	31,039	30,498	31,928	30,869	385,367
Memo: Quarterly Net Expense				88,071			100,248		93,653				83,395	
This line is input payment plug to the #.	385,367	33,173	31,892	33,006	31,998	33,048	35,202	30,206	31,408	31,039	30,498	31,928	30,869	385,367
		8.61%	8.28%	8.50%	8.30%	8.50%	9.13%	7.84%	8.41%	8.05%	7.91%	8.29%	8.04%	

*This report should be used for internal report only. Total Pharmaceutical Discovery Inc. - Do not share data for planning purposes only.

2000 Final AGU	32,133	30,404	35,911	33,138	32,058	45,704	28,013	27,124	29,769	26,703	27,355	26,418	374,730
2000 Actuals	32,133	30,404	35,911	33,138	32,058	45,704	28,013	27,124	29,769	26,703	27,355	26,418	374,730
1999 Actuals (Adjusted for Therapeutics)	21,427	23,683	25,358	24,208	25,970	24,288	25,942	24,819	23,961	28,343	27,940	40,589	315,443
1998 Actuals	21,582	23,967	27,222	25,213	23,774	25,866	24,495	23,269	26,430	33,783	24,554	42,270	322,225

Continued on next page

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CONFIDENTIAL
ABBT 0037518

6

PPRD FUNCTIONAL EXPENSE
RECONCILIATIONS YTD - \$
2001 PLAN

	Q1 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Discovery Deals * (742-505)	12,446	—	625	2,640	2,890	3,515	5,530	6,780	6,405	8,420	8,670	9,295	12,446
All Other Discovery *	140,636	11,481	22,842	34,449	45,978	57,551	69,165	80,779	92,741	104,759	116,795	128,851	140,636
Subtotal Pharmaceutical Discovery	153,082	11,481	23,467	37,089	48,866	61,066	74,695	86,559	99,146	113,179	125,485	138,146	153,082
DRUG SAFETY													
Experimental Science	8,919	589	1,358	2,100	2,815	3,531	4,263	4,996	5,730	6,451	7,173	7,896	8,919
Clinical Drug Analysis	5,129	423	848	1,270	1,895	2,120	2,551	2,983	3,415	3,843	4,271	4,700	5,129
Toxicology	8,489	524	1,049	1,568	2,123	2,601	3,205	3,750	4,290	4,838	5,381	5,925	6,489
Pathology	3,724	209	599	906	1,213	1,521	1,840	2,180	2,460	2,790	3,101	3,412	3,724
Comparative Medicine	11,022	915	1,832	2,749	3,666	4,584	5,502	6,421	7,340	8,260	9,180	10,101	11,022
Admin & Strategic	907	75	150	225	300	375	450	525	600	675	750	825	907
Strategic & Exploratory Science	3,442	284	568	853	1,138	1,423	1,713	2,003	2,294	2,581	2,868	3,150	3,442
Subtotal Drug Safety	39,312	3,210	6,430	9,089	12,050	15,215	18,524	22,839	26,157	29,441	32,729	36,020	39,312
MEDICAL AFFAIRS													
Administration (Cin Res - CNS)	2,942	226	453	680	927	1,175	1,430	1,685	1,941	2,191	2,441	2,692	2,942
Medical Services	7,398	596	1,197	1,809	2,423	3,040	3,658	4,278	4,899	5,522	6,148	6,771	7,398
Outcomes Research	1,743	124	248	366	525	664	817	970	1,124	1,278	1,432	1,587	1,743
Phase IV	6,706	497	1,023	1,509	2,125	2,682	3,249	3,822	4,397	4,973	5,550	6,128	6,706
Subtotal Medical Affairs	18,789	1,443	2,921	4,444	5,000	7,581	8,154	10,755	12,361	13,964	15,569	17,178	18,789
Information Mgmt & Technology													
Resource Management	2,464	203	407	611	810	1,021	1,220	1,432	1,639	1,840	2,053	2,261	2,464
Client Management	47,045	3,578	8,887	10,369	13,720	17,238	20,871	24,455	28,128	31,770	35,324	40,818	47,045
Technology Management	840	69	138	207	277	347	417	487	557	627	699	769	840
IM & T Admin	—	—	—	—	—	—	—	—	—	—	—	—	—
Subtotal Information Mgmt & Tech	50,349	3,848	7,442	11,187	14,813	18,608	22,314	26,374	30,324	34,243	38,076	43,846	50,349
Development Operations													
Data Management	7,119	588	1,177	1,767	2,358	2,950	3,543	4,137	4,732	5,328	5,925	6,522	7,119
Statistics	6,436	525	1,051	1,578	2,105	2,638	3,175	3,715	4,258	4,801	5,345	5,890	6,436
Abbott Res & Lib Info Svcs-ARLIS	3,251	206	532	709	1,048	1,285	1,551	1,807	2,063	2,320	2,577	2,825	3,251
Subtotal Development Operations	16,806	1,379	2,760	4,143	5,510	6,881	8,269	9,660	11,053	12,449	13,847	15,237	16,806
VENTURE MANAGEMENT													
Cardiovascular/Diabetes (CD)	—	—	—	—	—	—	—	—	—	—	—	—	—
Anti-Infective	8,732	453	920	1,388	1,867	2,347	2,828	3,310	3,792	4,273	4,751	5,231	5,712
Anti-Viral	10,405	867	1,735	2,604	3,474	4,345	5,217	6,090	6,963	7,837	8,712	9,588	10,465
Analgesia/ANM	5,748	494	989	1,482	1,971	2,461	2,952	3,443	3,934	4,424	4,915	5,406	5,897
Urology	2,021	167	334	501	668	837	1,005	1,174	1,343	1,512	1,681	1,851	2,021
Molecular Therapeutics	—	—	—	—	—	—	—	—	—	—	—	—	—
Neuroscience	—	—	—	—	—	—	—	—	—	—	—	—	—
Oncology	7,384	577	1,155	1,734	2,313	2,895	3,477	4,058	4,639	5,220	5,801	6,382	6,963
Subtotal Ventures	34,350	2,058	5,157	7,719	10,329	12,865	15,403	17,941	20,479	23,017	25,555	28,093	30,631
Administration	19,852	1,628	3,255	4,883	6,511	8,144	9,771	11,400	13,028	14,656	16,284	17,912	19,540
PARO	58,853	4,800	9,771	14,738	19,677	24,616	29,555	34,494	39,433	44,372	49,311	54,250	59,189
Regulatory Affairs	9,422	673	1,372	2,138	2,924	3,722	4,522	5,323	6,124	6,925	7,726	8,527	9,328
Phase-I Center	9,670	764	1,530	2,313	3,125	3,938	4,753	5,569	6,386	7,205	8,025	8,846	9,670
TOTAL FUNCTIONAL	410,285	31,852	64,191	98,348	130,713	163,750	198,354	231,435	268,204	303,378	337,735	372,423	410,285
Minus: % of Total Func, excl. Disc Deals	—	8.0%	16.0%	24.1%	32.1%	40.3%	48.5%	56.7%	65.0%	74.1%	82.7%	91.3%	100.0%
International Manpower	4,105	287	577	862	1,148	1,518	1,785	2,217	2,688	3,120	3,551	3,981	4,105
Clinical Grants	118,028	9,273	18,505	28,010	37,008	47,892	58,198	69,002	79,813	89,829	99,816	107,382	118,028
QA/SA Services Purchased	100,707	9,075	18,150	28,418	35,150	43,412	50,319	58,571	66,823	74,936	83,053	92,370	100,707
Corporate Tax	—	—	—	—	—	—	—	—	—	—	—	—	—
Judgment - Internal	8,060	5,689	8,570	10,520	11,809	14,088	16,823	17,258	14,205	12,070	12,809	11,287	8,060
Judgment - Published	(9,600)	(817)	(1,634)	(2,451)	(3,268)	(4,085)	(4,902)	(5,719)	(6,536)	(7,352)	(8,168)	(8,984)	(9,600)
Global reimbursement from Commercial	—	—	—	—	—	—	—	—	—	—	—	—	—
Hand Post/Flash to Actual Adjustment	—	—	—	—	—	—	—	—	—	—	—	—	—
Other Project Changes:	—	—	—	—	—	—	—	—	—	—	—	—	—
Gross PPD R&D Expense	629,385	54,338	106,445	160,305	212,629	266,392	323,557	372,824	425,237	475,979	526,055	578,439	629,385
QA/SA Services Sold	(244,018)	(21,105)	(41,380)	(62,234)	(82,560)	(103,275)	(125,238)	(144,289)	(164,304)	(184,007)	(203,586)	(224,041)	(244,018)
Net PPD R&D Expense	385,367	33,233	65,065	98,071	130,069	163,117	198,319	228,535	260,933	291,972	322,470	354,398	385,367

* Do not report these lines for actuals; report only Total Pharmaceutical Discovery Exp. Detail is shown here for planning purposes only.

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PPPD SERVICES PURCHASED
RECONCILIATIONS MONTH - \$
2001 PLAN

UNIT
DOLLAR

	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Patents & Trademark	6,050	504	504	504	504	504	504	504	504	504	504	504	506	6,050
Corp Admin Fixed	5,445	454	454	454	454	454	454	454	454	454	454	454	451	5,445
Corp Cost Pools	5,070	423	423	423	423	423	423	423	423	423	423	423	417	5,070
Satellite Copy Charge	539	45	45	45	45	45	45	45	45	45	45	45	44	539
CHMO Services Purchased Fixed (AHD)	196	16	16	16	16	16	16	16	16	16	16	16	20	196
PPD Ops Fixed Allocations	3,232	269	269	269	269	269	269	269	269	269	269	269	273	3,232
CENG - Fixed Maintenance from PPD O	899	75	75	75	75	75	75	75	75	75	75	75	74	899
CHEN Variable (EWRIS)	147	12	12	12	12	12	12	12	12	12	12	12	15	147
CMIS - Purchasing	747	62	62	62	62	62	62	62	62	62	62	62	65	747
CHMS Telecommunications	130	11	11	11	11	11	11	11	11	11	11	11	9	130
Fixed L C Exp - Admin. Services	421	35	35	35	35	35	35	35	35	35	35	35	38	421
Corp Eng EHS Fixed Allocation	587	50	50	50	50	50	50	50	50	50	50	50	47	587
TOTAL CORPORATE ALLOCATION	23,473	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,956	1,957	23,473
CMIS - Unit of Activity, Fixed - Other	2,667	222	222	222	222	222	222	222	222	222	222	222	225	2,667
CMIS - Unit of Activity, Fixed - Aegis	2,100	175	175	175	175	175	175	175	175	175	175	175	175	2,100
PPD Personnel D0A47	2,601	217	217	217	217	217	217	217	217	217	217	217	214	2,601
PPD Mfg Ops - Allocation	63	5	5	5	5	5	5	5	5	5	5	5	8	63
PPD Ops QA Int Svcs/Reg Affairs	1,942	162	162	162	162	162	162	162	162	162	162	162	160	1,942
PPD Ops Returned Goods	136	11	11	11	11	11	11	11	11	11	11	11	15	136
Project Expense	7,092	592	592	592	592	592	592	592	592	592	592	592	587	7,092
TOTAL BURDEN FILE	40,081	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,340	3,341	40,081
SPD Pilot Plant Stock Card	24,497	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,035	24,497
SPD Bulk Direct (Chem/Farm)	17,328	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	17,328
Excess Capacity Stock Card	11,810	968	968	968	968	968	968	968	968	968	968	968	962	11,810
Subtotal SPD (Other than TAP)	53,635	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,635
TAP Bulk Drug (D-TAP)	84	7	7	7	7	7	7	7	7	7	7	7	7	84
TAP - SPD Manpower & Bulk (D-453)	245	20	20	20	20	20	20	20	20	20	20	20	25	245
Pharmacogenetics - ADD Allocation	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Expense	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal (For Exp Cat)	329	27	27	27	27	27	27	27	27	27	27	27	32	329
Other Purchases:														
Clear Once-A-Day (Global AI Manpower)	7,763	973	973	973	973	483	483	483	483	483	483	483	487	7,763
Corp Drug User Fees	1,207	---	---	---	---	---	---	---	---	1,207	---	---	---	1,207
Patent to Operations (search services)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
D-AS4 Floor Space (not in functionals)	182	15	15	15	15	15	15	15	15	15	15	15	17	182
D-AS4 Deprec (not in functionals)	2,984	249	249	249	249	249	249	249	249	249	249	249	245	2,984
Molecular Probes	7	---	---	---	---	---	---	---	---	---	---	---	---	7
Inventory transfer for Protease 2nd Gen	---	---	---	---	---	---	---	---	---	---	---	---	---	---
SDG/Other	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Clinical Supplies (Tricia Goren -PPD Op	200	17	17	17	17	17	17	17	17	17	16	16	16	200
Aegis Charges	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Library (D441) to CHMS	---	---	---	---	---	---	---	---	---	---	---	---	---	---
QA (D44N) to Operations	1,500	---	---	---	---	---	---	---	---	---	---	---	---	1,500
Sangstat (Cyclosporine)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Sangstat (Sangcy2)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Gabril Royalty	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Ritonavir/Lutroche Combo	---	---	---	---	---	---	---	---	---	---	---	---	---	---
NOVO Settlement	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Metabiox	---	---	---	---	---	---	---	---	---	---	---	---	---	---
FLAP/Vanguard	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Sandoz Cost Sharing w/Gabril	---	---	---	---	---	---	---	---	---	---	---	---	---	---
CI change from DPS (Cin Val Mgr) + \$4	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Triangle receipt \$2,935 + \$325 for 1999	(5,381)	---	---	(507)	---	---	(1,345)	---	---	(1,345)	---	---	(1,884)	(5,381)
Comisco	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Hydrocodone (IDV-4n from HPD)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
CRO Rebates	(3,000)	---	---	---	(333)	(333)	(333)	(333)	(333)	(333)	(334)	(334)	(334)	(3,000)
Gabril Reimbursement from Commercial	1,400	---	---	---	---	---	---	---	---	---	467	467	466	1,400
Other	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Grand Total	199,707	9,076	9,076	9,268	9,742	8,252	6,907	8,252	8,252	8,113	8,717	8,717	8,334	199,707

(2,537)

LCR0000000000000000 PLAN0001 FINAL OPERATIONAL

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ABBT 0037520

8

PPRD SERVICES PURCHASED
RECONCILIATIONS YTD - \$
2001 PLAN

01/28/01
09:12 AM

	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Patents & Trademark	6,050	504	1,008	1,512	2,016	2,520	3,024	3,528	4,032	4,536	5,040	5,544	6,050
Corp Admin Fixed	5,445	454	908	1,362	1,816	2,270	2,724	3,178	3,632	4,086	4,540	4,994	5,445
Corp Cost Pools	5,070	423	846	1,269	1,692	2,115	2,538	2,961	3,384	3,807	4,230	4,653	5,070
Satellite Copy Charge	539	45	90	135	180	225	270	315	360	405	450	495	539
CHMD Services Purchased Fixed (AHD)	196	16	32	48	64	80	96	112	128	144	160	176	196
PPD Ops Fixed Allocations	3,232	269	538	807	1,076	1,345	1,614	1,883	2,152	2,421	2,690	2,959	3,232
CENG - Fixed Maintenance from PPD O	899	75	150	225	300	375	450	525	600	675	750	825	899
CHEN Variable (EYRS)	147	12	24	36	48	60	72	84	96	108	120	132	147
CHMS - Purchasing	747	62	124	186	248	310	372	434	496	558	620	682	747
CHMS Telecommunications	130	11	22	33	44	55	66	77	88	99	110	121	130
Fixed L.C. Exp - Admin. Services	421	35	70	105	140	175	210	245	280	315	350	385	421
Corp Eng EHS Fixed Allocation	597	50	100	150	200	250	300	350	400	450	500	550	597
TOTAL CORPORATE ALLOCATION	23,473	1,956	3,912	5,868	7,824	9,780	11,736	13,692	15,648	17,604	19,560	21,516	23,473
CHMS - Unit of Activity, Fixed - Other	2,067	222	444	666	888	1,110	1,332	1,554	1,776	1,998	2,220	2,442	2,667
CHMS - Unit of Activity, Fixed - Aegis	2,100	175	350	525	700	875	1,050	1,225	1,400	1,575	1,750	1,925	2,100
PPD Personnel DCA47	2,601	217	434	651	868	1,085	1,302	1,519	1,736	1,953	2,170	2,387	2,601
PPD Mfg Ops - Allocation	63	5	10	15	20	25	30	35	40	45	50	55	63
PPD Ops QA/Inf Svcs/Reg Affairs	1,942	162	324	486	648	810	972	1,134	1,296	1,458	1,620	1,782	1,942
PPD Ops Returned Goods	136	11	22	33	44	55	66	77	88	99	110	121	136
Project Expense	7,098	592	1,184	1,776	2,368	2,960	3,552	4,144	4,736	5,328	5,920	6,512	7,098
TOTAL BURDEN FILE	40,081	3,340	6,680	10,020	13,360	16,700	20,040	23,380	26,720	30,060	33,400	36,740	40,081
SPD Pilot Plant Stock Card	24,497	2,042	4,084	6,126	8,168	10,210	12,252	14,294	16,336	18,378	20,420	22,462	24,497
SPD Bulk Direct (Chem/Farm)	17,328	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328
Excess Capacity Stock Card	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610
Subtotal SPD (Other than TAP)	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435
TAP Bulk Drug (D-TAP)	84	7	14	21	28	35	42	49	56	63	70	77	84
TAP - SPD Manpower & Bulk (D-453)	245	20	40	60	80	100	120	140	160	180	200	220	245
Pharmacogenetics - ADD Allocation	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Expense	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal (For Exp Call)	329	27	54	81	108	135	162	189	216	243	270	297	329
Other Purchases:	---	---	---	---	---	---	---	---	---	---	---	---	---
Cost Once-A-Day (Global AI Manpower)	7,753	973	1,947	2,920	3,893	4,876	5,850	6,823	7,796	8,769	9,742	10,715	11,688
Corp Drug User Fees	1,207	---	---	---	---	---	---	---	---	---	---	---	---
Patent to Operations (search services)	---	---	---	---	---	---	---	---	---	---	---	---	---
D-A54 Floor Space (not in functionals)	182	15	30	45	60	75	90	105	120	135	150	165	182
D-A54 Deprec (not in functionals)	2,984	249	498	747	996	1,245	1,494	1,743	1,992	2,241	2,490	2,739	2,984
Molecular Probes	7	---	---	---	---	---	---	---	---	---	---	---	---
Inventory transfer for Protease 2nd Gen	---	---	---	---	---	---	---	---	---	---	---	---	---
SDG/Other	---	---	---	---	---	---	---	---	---	---	---	---	---
Clinical Supplies (Tricks Geran - PPD Op	200	17	34	51	68	85	102	119	136	152	169	184	200
Aegis Charges	---	---	---	---	---	---	---	---	---	---	---	---	---
Library (D441) to CHMS	---	---	---	---	---	---	---	---	---	---	---	---	---
QA (D44N) to Operations	1,500	---	---	---	---	---	---	---	---	---	---	---	---
Sangstat (Cyclosporine)	---	---	---	---	---	---	---	---	---	---	---	---	---
Sangstat (Sangcya)	---	---	---	---	---	---	---	---	---	---	---	---	---
Gabril Royalty	---	---	---	---	---	---	---	---	---	---	---	---	---
Ritonavir/La Roche Combo	---	---	---	---	---	---	---	---	---	---	---	---	---
NOVO Settlement	---	---	---	---	---	---	---	---	---	---	---	---	---
Malabolex	---	---	---	---	---	---	---	---	---	---	---	---	---
FLAP/Vanguard	---	---	---	---	---	---	---	---	---	---	---	---	---
Sano6 Cost Sharing w/Gabril	---	---	---	---	---	---	---	---	---	---	---	---	---
CI charge from OPS (Cin Val Mgr) + \$4	---	---	---	---	---	---	---	---	---	---	---	---	---
Triangle receipt \$2,935 + \$325 for 1999	(5,381)	---	---	(807)	(807)	(807)	(2,152)	(2,152)	(2,152)	(3,497)	(3,497)	(3,497)	(5,381)
Comdisco	---	---	---	---	---	---	---	---	---	---	---	---	---
Hydrocodone (IDV-in from HPD)	---	---	---	---	---	---	---	---	---	---	---	---	---
CRO Rebates	(3,000)	---	---	---	(333)	(666)	(999)	(1,332)	(1,665)	(1,998)	(2,331)	(2,664)	(3,000)
Gabril Reimbursement from Commend	1,400	---	---	---	---	---	---	---	---	---	---	---	---
Other	---	---	---	---	---	---	---	---	---	---	---	---	---
Grand Total	100,707	9,075	18,151	27,227	36,303	45,379	54,455	63,531	72,607	81,683	90,759	99,835	108,911

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9

PPRD SERVICES SOLD
RECONCILIATIONS MONTH - \$
2001 PLAN

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	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
% RATE - ACTUALS														
% RATE - MONTHLY PROJECTION														
Cumulative % Rate														
% RATE - ADJUSTED PROJECTION														
AI GLOBAL PHARMACEUTICAL	185,570	16,385	15,435	16,074	15,546	15,935	17,183	14,280	15,224	14,922	14,798	15,674	15,214	185,570
Direct Sister Benefit														
R&D Scientific Service (Fixed)	2,384	199	199	199	199	199	199	199	199	199	199	199	199	2,384
Direct Services	3,800	317	317	317	317	317	317	317	317	317	317	317	317	3,800
Total Direct Sister Benefit	6,184	516	516	516	516	516	516	516	516	516	516	516	516	6,184
Total Int'l Sister Division	192,854	16,901	15,951	16,590	16,062	16,451	17,699	14,796	15,740	15,439	15,314	16,190	15,722	192,854
TAP - SPD Manpower	245	20	20	20	20	20	20	20	20	20	20	20	25	245
TAP - Judgment (Positive Controls)														
TAP - Bulk Drug	84	7	7	7	7	7	7	7	7	7	7	7	7	84
TAP - All Other	19,850	1,652	1,652	1,652	1,652	1,652	1,652	1,652	1,652	1,652	1,652	1,652	1,652	19,850
Total TAP	20,185	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,683	20,185
Domestic Sister Divisions														
HPD	8,534	736	736	736	736	736	736	736	736	736	736	736	736	8,534
ADD	2,383	199	199	199	199	199	199	199	199	199	199	199	194	2,383
SPD	4,909	409	409	409	409	409	409	409	409	409	409	409	410	4,909
ROSS	1,955	163	163	163	163	163	163	163	163	163	163	163	162	1,955
CPD	42	4	4	4	4	4	4	4	4	4	4	4	(2)	42
MIS	74	6	6	6	6	6	6	6	6	6	6	6	8	74
AHD (AHS Abbott Health Systems)														
CHMS Library Charges														
Corp Eng														
Total Domestic Sister Division	16,197	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,517	1,510	16,197
Other Sister Divisions:														
Corp Administration														
Corp Admin.	24	2	2	2	2	2	2	2	2	2	2	2	2	24
TAP Rate Dis (Fixed)	485	40	40	40	40	40	40	40	40	40	40	40	45	485
Symposium Expense (Fixed)	152	14	14	14	14	14	14	14	14	14	14	14	11	152
Subtotal CHAD	674	56	56	56	56	56	56	56	56	56	56	56	58	674
PPD Product R&D														
Mig Support (MG,PM)	12,215	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,018	1,017	12,215
Mig Support (PV)	263	22	22	22	22	22	22	22	22	22	22	22	21	263
PPD Marketing (PS,PD) (Inc Cephalon)	3,620	302	302	302	302	302	302	302	302	302	302	302	298	3,620
Subtotal Other	16,098	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,342	1,336	16,098
VAT Refund														
PPRD Services Sold Impact (Judgment)	(3,980)	(333)	(333)	(333)	(333)	(333)	(333)	(332)	(332)	(332)	(332)	(332)	(332)	(3,980)
Rounding														
GRAND TOTAL	244,018	21,165	20,215	20,854	20,325	20,715	21,953	19,061	20,085	19,703	19,579	20,455	19,877	244,018
Memo: Excluding Global - \$		4,780	4,780	4,780	4,780	4,780	4,780	4,781	4,781	4,781	4,781	4,781	4,763	57,348
Quarterly - \$							14,340			14,343			14,325	57,348
Excluding Global - % of Qtr				25.0%			25.0%			25.0%			25.0%	
Excluding Global - % Dec													8.3%	

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PPRD SERVICES SOLD
RECONCILIATIONS YTD - \$
2001 PLAN

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	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
AJ GLOBAL PHARMACEUTICAL	186,670	16,385	31,820	47,894	63,440	79,375	96,558	110,538	126,062	140,984	155,782	171,456	186,670
Direct Sister Benefit													
R&D Scientific Service (fixed)	2,384	199	358	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,384
Direct Service	3,800	317	634	951	1,268	1,585	1,902	2,219	2,536	2,853	3,170	3,487	3,800
Total Direct Sister Benefit	6,184	516	1,032	1,548	2,064	2,580	3,096	3,612	4,128	4,644	5,160	5,676	6,184
Total Intl Sister Division	192,854	16,901	32,852	49,442	65,504	81,955	99,654	114,450	130,190	145,628	160,942	177,132	192,854
TAP - SPD Manpower	245	20	40	60	80	100	120	140	160	180	200	220	245
TAP - Judgment	84	7	14	21	28	35	42	49	56	63	70	77	84
TAP - Bulk	19,856	1,855	3,310	4,865	6,420	7,975	9,530	11,085	12,640	14,195	15,750	17,305	18,856
TAP - All Other	20,185	1,682	3,384	5,046	6,728	8,410	10,092	11,774	13,456	15,138	16,820	18,502	20,185
Total TAP													
Domestic Sister Divisions													
HPD	8,634	738	1,472	2,208	2,944	3,680	4,416	5,152	5,888	6,624	7,360	8,096	8,834
ADD	2,383	198	398	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,383
SPD	4,909	409	818	1,227	1,636	2,045	2,454	2,863	3,272	3,681	4,090	4,499	4,909
ROSS	1,955	163	326	489	652	815	978	1,141	1,304	1,467	1,630	1,793	1,955
CPD	42	4	8	12	16	20	24	28	32	36	40	44	42
MIS	74	6	12	18	24	30	36	42	48	54	60	66	74
AHD (AHS Abbott Health Systems)	—	—	—	—	—	—	—	—	—	—	—	—	—
CHMS Library Charges	—	—	—	—	—	—	—	—	—	—	—	—	—
Corp Eng	—	—	—	—	—	—	—	—	—	—	—	—	—
Total Domestic Sister Division	18,187	1,517	3,034	4,551	6,068	7,585	9,102	10,619	12,136	13,653	15,170	16,687	18,187
Other Sister Divisions:													
Corp Administration	24	2	4	6	8	10	12	14	16	18	20	22	24
Corp. Admin.	485	40	80	120	160	200	240	280	320	360	400	440	485
TAP Rate Diff	185	14	28	42	56	70	84	98	112	126	140	154	185
Symposium Expense	674	56	112	168	224	280	336	392	448	504	560	616	674
Subtotal CHAD													
PPD Product R&D	12,215	1,018	2,036	3,054	4,072	5,090	6,108	7,126	8,144	9,162	10,180	11,198	12,215
Mfg Support (MC,PM)	263	22	44	66	88	110	132	154	176	198	220	242	263
Mfg Support (PV)													
PPD Marketing (P5,P6) (Inc Cephalon)	3,620	302	604	906	1,208	1,510	1,812	2,114	2,416	2,718	3,020	3,322	3,620
Subtotal Other	16,098	1,342	2,684	4,026	5,368	6,710	8,052	9,394	10,736	12,078	13,420	14,762	16,098
VAT Refund	—	—	—	—	—	—	—	—	—	—	—	—	—
PARD Services Sold Impact (Judgeme	(3,990)	(333)	(666)	(999)	(1,332)	(1,665)	(1,998)	(2,330)	(2,662)	(2,994)	(3,326)	(3,659)	(3,990)
Rounding	—	—	—	—	—	—	—	—	—	—	—	—	—
GRAND TOTAL	244,018	21,165	41,380	62,234	82,560	103,275	125,238	144,299	164,304	184,007	203,586	224,041	244,018

LAURENCE/PLANNING/0001 PLAN/001 FINAL - Dec 01/00

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ABBT 0037523

PPD CLINICAL GRANTS
RECONCILIATIONS - YTD \$
2001 PLAN

	Y1 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
PPD SERVICE:													
Tragabine/Gabitril	3,600	--	--	--	--	--	--	--	600	1,200	1,800	2,400	3,000
Omnicef	9,441	723	635	1,816	2,894	4,176	5,254	6,534	7,715	8,323	8,690	9,069	9,441
Depakote/Depakene	--	--	--	--	--	--	--	--	--	--	--	--	--
Pro-UK	39	39	39	39	39	39	39	39	39	39	39	39	39
Fenofibrate (Fenofibrate)	600	--	120	240	360	480	600	600	600	600	600	600	600
Hematin	200	--	--	20	40	60	80	100	120	140	160	180	200
PharmacoGenetics (Genset)	--	--	--	--	--	--	--	--	--	--	--	--	--
TOTAL PPD SERVICE	13,280	762	794	2,115	3,433	4,752	6,073	7,273	8,074	10,302	11,295	12,268	13,280
GLOBAL SERVICE:													
Rilovir ABT-538	1,244	299	157	266	375	484	593	702	811	920	1,028	1,136	1,244
Pyklos 2nd Gen ABT-378	22,575	120	1,838	3,830	5,831	8,074	10,313	12,479	14,634	16,587	18,563	20,579	22,575
Dopamine	380	--	--	--	--	--	--	--	--	--	--	180	380
KCO ABT-538	1,065	100	130	231	351	471	591	711	831	951	1,071	1,191	1,311
ABT-538 (formerly CCM)	--	--	--	--	--	--	--	--	--	--	--	--	--
ABT-538 (formerly CHCM)	2,840	172	344	604	864	1,124	1,384	1,644	1,904	2,163	2,422	2,681	2,940
Carbonyls	47,405	4,847	9,694	14,541	19,387	24,233	29,079	33,925	38,771	43,617	48,463	53,309	58,155
Ketide ABT-773	--	--	--	--	--	--	--	--	--	--	--	--	--
Prokinetic Macrolide - Dom	--	--	--	--	--	--	--	--	--	--	--	--	--
Zenon & 2nd Generation	--	--	--	--	--	--	--	--	--	--	--	--	--
BPH ABT-980	993	464	499	624	739	854	969	1,084	1,199	1,314	1,429	1,544	1,659
Cyclosporine	--	--	--	--	--	--	--	--	--	--	--	--	--
H2O (Medivac)	18,251	1,035	2,070	3,105	4,140	5,175	6,210	7,245	8,280	9,315	10,350	11,385	12,420
Endobol	--	--	--	--	--	--	--	--	--	--	--	--	--
NS 48 Nippon Shinyaku ABT-23	--	--	--	--	--	--	--	--	--	--	--	--	--
Bimodonef (Bionet)	--	--	--	--	75	150	225	300	375	450	525	600	675
Anti-Malaric ABT-751	1,025	--	--	--	--	--	--	--	--	--	--	--	--
Hydro	1,118	64	128	192	256	320	384	448	512	576	640	704	768
MAR (Mekloprolase)	--	--	--	--	--	--	--	--	--	--	--	--	--
Tacrine	1,621	116	232	348	464	580	696	812	928	1,044	1,160	1,276	1,392
YSP Peptide	5,000	229	368	547	856	1,065	1,274	1,483	1,692	1,901	2,110	2,319	2,528
Quinolone	131	65	131	196	261	326	391	456	521	586	651	716	781
Doc 8	--	--	--	--	--	--	--	--	--	--	--	--	--
Neuronalase	--	--	--	--	--	--	--	--	--	--	--	--	--
Adjustment (EVR)	--	--	--	--	--	--	--	--	--	--	--	--	--
TOTAL GLOBAL SERVICE	104,748	7,511	15,711	24,497	33,633	42,939	52,125	61,729	70,739	79,527	88,221	96,964	104,748
Vitamin D Analog/Pro Dextran	--	--	--	--	--	--	--	--	--	--	--	--	--
Isobutylmethylcarbamate	--	--	--	--	--	--	--	--	--	--	--	--	--
Adjustments	--	--	--	--	--	--	--	--	--	--	--	--	--
Demethylation/Zenylar (HPD)	--	--	--	--	--	--	--	--	--	--	--	--	--
Tyrosine Reformulation	--	--	--	--	--	--	--	--	--	--	--	--	--
Epain Reformulation	--	--	--	--	--	--	--	--	--	--	--	--	--
GRAND TOTAL GRANTS	118,028	8,273	16,505	25,612	37,066	47,692	58,198	68,002	78,813	89,829	100,616	110,232	118,028

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PPD CLINICAL GRANTS RECONCILIATIONS - YTD \$ 2001 PLAN

PPD CLINICAL GRANTS RECONCILIATIONS - YTD \$ 2001 PLAN

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ABIT 0037525

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NOTES

* These 4 most powerful algorithms have been described, formulated to explain the same outcome at least for the most and are defined in which the most important and 4 types in the system. These notes should be understood with the system and the underlying concepts, they read the same as the subject in this article and the system.

* This model about algorithm only contains 4 types in the system, should be 4 types, the other 4 types are produced in the system.

1. **Introduction**

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PPRD GREYBOOK
RECONCILIATIONS MONTH - 8
2001 PLAN

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	GLOBAL														
	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL	
CHARGES TO PROJECTS:															
<i>Memo: Global Key Check</i>															
Global	486,675	40,963	38,588	40,185	38,865	39,837	42,858	35,700	38,080	37,305	36,995	39,185	38,034	486,675	
Direct Service	105,362	8,202	8,406	8,562	8,346	8,813	9,084	8,454	9,240	8,324	7,969	8,085	11,807	105,362	
PPD Service	57,348	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	5,113	1,105	57,348	
Sister & Takeda															
TOTAL GROSS EXPENSE	629,385	54,338	52,107	53,860	52,324	53,763	57,165	49,267	52,413	50,742	50,077	52,383	50,945	629,385	
LESS SISTER DIVISION CHARGES:															
AI Total	192,854	16,901	15,951	16,590	16,062	16,451	17,599	14,796	15,740	15,438	15,314	16,180	15,722	192,854	
TAP Pharm. Inc.	20,185	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	1,682	20,185	
HPD	8,834	736	736	736	736	736	736	736	736	736	736	736	736	8,834	
ADD	2,383	199	199	199	199	199	199	199	199	199	199	199	199	2,383	
SPD	4,809	409	409	409	409	409	409	409	409	409	409	409	409	4,809	
ROSS	1,855	163	163	163	163	163	163	163	163	163	163	163	163	1,855	
CPD	42	4	4	4	4	4	4	4	4	4	4	4	4	42	
CMIS	74	6	6	6	6	6	6	6	6	6	6	6	6	74	
Other Sister Division	16,772	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,398	1,394	16,772	
TOTAL CHARGES OUT	248,008	21,498	20,548	21,187	20,559	21,048	22,299	19,393	20,337	20,035	19,911	20,767	20,309	248,008	
PARD SERVICES SOLD IMPACT (Judgement)	3,890	333	333	333	333	333	333	332	332	332	332	332	332	3,890	
NET PPRD EXPENSE	385,367	33,173	31,892	33,006	31,899	33,048	35,202	30,206	32,408	31,039	30,498	31,928	30,869	385,367	
ACTUALS PER GREYBOOK (J:DRIVE)															
VARIANCE/KEY CHECK		(33,173)	(31,892)	(33,006)	(31,899)	(33,048)	(35,202)	(30,206)	(32,408)	(31,039)	(30,498)	(31,928)	(30,869)	(385,367)	
ACTUALS PER KIRNES/DIANA															
VARIANCE/KEY CHECK		(33,173)	(31,892)	(33,006)	(31,899)	(33,048)	(35,202)	(30,206)	(32,408)	(31,039)	(30,498)	(31,928)	(30,869)	(385,367)	
<i>Memo: 2000 Actuals</i>		32,133	30,404	35,911	33,138	32,858	45,704	28,013	27,124	29,386	27,095	27,116	27,512	376,593	
<i>Memo:</i>															
AI 2001 PLAN (12/08/00)		16,901	15,951	16,590	16,062	16,451	17,599	14,796	15,740	15,438	15,314	16,180	15,722	192,854	
AI Final 2000 AGU		10,645	14,364	14,799	14,474	16,424	17,281	17,969	15,360	19,401	19,301	16,441	15,581	192,040	
Net PPRD Expense		1Qtr	2Qtr	3Qtr	4Qtr	Total									
2001 PLAN (12/08/00)		98,071	100,248	93,653	83,395	385,367									
% of total		25.4%	26.0%	24.3%	21.6%	100.0%									
2000 Final AGU		98,448	110,900	84,906	80,478	374,730									
% of total		26.3%	29.6%	22.7%	21.5%	100.0%									
2000 Actuals		98,448	110,900	84,523	81,722	375,593									
% of total		26.2%	29.5%	22.5%	21.8%	100.0%									
		1Qtr	2Qtr	3Qtr	4Qtr	Total									
2001 PLAN Fav/(Unfav) vs.															
		377	10,652	(8,747)	(12,819)	(10,637)									
		0.4%	9.6%	-10.3%	-16.1%	-2.8%									
		377	10,652	(9,130)	(11,573)	(9,774)									
		0.4%	9.6%	-10.8%	-14.3%	-2.6%									

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PPRD GREYBOOK
RECONCILIATIONS YTD - \$
2001 PLAN

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ABBOTT AB

2001 PLAN	GLOBAL												
CHARGES TO PROJECTS:	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Global	466,676	40,963	79,551	110,736	158,601	198,438	241,396	277,096	315,156	352,461	389,456	428,641	466,675
Direct Service													
PPD Service	105,362	8,262	16,888	25,230	33,576	42,389	51,483	59,937	68,177	77,501	85,470	93,555	105,362
Sister & Takeda	57,348	5,113	10,226	15,339	20,452	25,565	30,678	35,791	40,904	46,017	51,130	56,243	57,348
TOTAL GROSS EXPENSE	629,385	54,338	106,445	160,305	212,629	266,392	323,557	372,824	425,237	475,978	526,056	578,439	629,385
LESS SISTER DIVISION CHARGES:													
AI Total	182,854	16,901	32,852	49,442	65,504	81,955	99,854	114,450	130,180	145,628	160,942	177,132	182,854
TAP Pharm, Inc.	20,185	1,682	3,364	5,046	6,728	8,410	10,092	11,774	13,456	15,138	16,820	18,502	20,185
HPD	8,834	738	1,472	2,208	2,944	3,680	4,416	5,152	5,888	6,624	7,360	8,096	8,834
ADD	2,383	199	398	597	796	995	1,194	1,393	1,592	1,791	1,990	2,189	2,383
SPD	4,809	409	818	1,227	1,636	2,045	2,454	2,863	3,272	3,681	4,090	4,499	4,809
ROSS	1,855	163	326	489	652	815	978	1,141	1,304	1,467	1,630	1,793	1,855
CPD	42	4	8	12	16	20	24	28	32	36	40	44	42
CMIS	74	6	12	18	24	30	36	42	48	54	60	66	74
Other Sister Division	16,772	1,398	2,796	4,194	5,592	6,990	8,388	9,786	11,184	12,582	13,980	15,378	16,772
TOTAL CHARGES OUT	248,008	21,488	42,048	63,233	83,892	104,940	127,236	149,629	169,966	187,001	206,812	227,699	248,008
PARD SERVICES SOLD IMPACT (Judgement)	3,990	333	666	999	1,332	1,665	1,998	2,330	2,662	2,994	3,326	3,658	3,990
NET PPRD EXPENSE	385,367	33,173	65,065	98,071	130,069	163,117	198,319	228,525	260,833	291,972	322,470	354,398	385,367

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PPD RESEARCH AND DEVELOPMENT
2001 PLAN
P&L AI CALENDARIZATION

02/19/01
DEBT:AM

Modeling Factor: Input # months actuals in cell below	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Modeling Factor: Input total Global \$'s in cell below													
Global:													
Discovery Deals	0	525	2,015	250	625	2,015	250	625	2,015	250	625	3,151	12,446
Consol Payments	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7,511	8,200	8,785	9,136	9,308	10,196	8,604	9,010	8,788	5,794	9,773	9,654	104,748
Global Grants	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,916	47,069
Global SPD													
Subtotal - Identified Global Expenses	11,434	12,748	14,724	13,309	13,854	16,124	12,777	13,538	14,726	9,967	14,321	16,721	184,263
All Other (see allocation basis at Memo 1)	28,321	26,504	25,267	25,085	25,904	29,801	23,655	24,836	23,141	26,028	24,689	21,880	302,412
Total Global as Calculated	39,755	39,252	39,991	38,395	39,758	42,925	36,332	38,374	37,867	35,995	39,010	38,701	486,675
Adjust to From AI Selloff	1,208	(564)	194	470	79	33	(532)	(334)	(582)	1,000	175	(667)	0
Modeling Factor: If freezing AI selloff, input 1. If AI selloff can 1													
Total Global	40,963	38,688	40,185	38,865	39,837	42,958	35,700	38,040	37,285	36,995	39,185	38,034	486,675
Less AI Share	(16,365)	(15,435)	(16,074)	(15,546)	(15,935)	(17,163)	(14,280)	(15,224)	(14,922)	(14,798)	(15,674)	(15,214)	(186,670)
Domestic:													
Domestic Grants	782	32	1,319	1,320	1,320	1,320	1,200	1,801	1,228	993	993	992	(104,748)
Domestic SPD	531	531	531	531	531	531	531	531	531	531	531	525	6,360
Subtotal - Identified Domestic Expenses	1,293	563	1,850	1,851	1,851	1,851	1,731	2,332	1,759	1,524	1,524	1,517	(88,382)
All Other	7,302	8,176	7,045	6,828	7,295	7,576	7,055	7,240	6,997	6,777	6,693	6,632	85,718
Total Domestic	8,595	8,739	8,895	8,679	9,146	9,427	8,786	9,572	8,756	8,301	8,417	8,149	105,362
Memo 1:													
Total Net PPD R&D Expense	33,173	31,892	33,006	31,998	33,048	35,202	30,206	32,408	31,039	30,498	31,928	30,969	385,367
Less 100% of Identified Domestic Exp (above)	(1,293)	(563)	(1,850)	(1,851)	(1,851)	(1,851)	(1,731)	(2,332)	(1,759)	(1,524)	(1,524)	(1,517)	(19,646)
Less 50% of Identified Global Exp (above)	(6,880)	(7,640)	(8,834)	(7,989)	(9,312)	(18,874)	(7,669)	(8,135)	(8,836)	(5,980)	(8,593)	(10,033)	(88,557)
All Other Not yet Calendarized (Allocation base)	25,020	23,880	22,322	22,162	22,885	22,677	20,809	21,941	20,444	22,894	21,811	19,416	267,163
Calculating preliminary calendarizations for TRM review packages													
1) Input actuals to detailed model. Confirm that net R&D ties to J drive (P&L/P&L/CAL/VW4).													
2) Input items pulling into "Identified Global Expenses" and "Identified Domestic Expenses" above													
- From analysts: Discovery New Technology, Grants, SPD, License payments, refunds, etc.													
- We can guessimate Discovery functionalities													
3) Input modeling factors above (8 months actuals and total global \$'s)													
4) Make sure calendarization sheets (column 8 in Global Grants, Func Expense, Swat Purchased, Swat Sold) are pulling correct annual \$ from Op Cost Stmt													
5) Model Quarterly Profile													
6) Model net R&D calendarization below. (Inputs are in blue.) Plug all other to achieve qtrly profile													
7) For APJ preliminary estimates, March = Flash, April = Plan + Blue Plan Impact													
For AGU preliminary estimates, July = Flash (if not available, use APJ + BP), August = APJ + Blue Plan Impact.													
8) Input Net R&D (as calculated below) to Func Expense Net Income sheet Line 01, on "This is input, judgment plugs to this # line."													
Identified Global Expenses (Net)	6,880	7,640	8,834	7,985	9,312	9,674	7,666	8,135	8,836	5,980	8,593	10,033	88,557
Identified Domestic Expenses	1,293	563	1,850	1,851	1,851	1,851	1,731	2,332	1,759	1,524	1,524	1,517	19,646
Payroll	0	200	400	600	800	1,000	1,200	1,400	1,600	1,800	2,000	2,200	13,200
Adjustment for PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal - Identified Net Expenses	8,163	8,412	11,084	10,436	10,963	12,525	10,597	11,867	12,195	8,304	12,117	13,750	131,403
All Other - see (a) for Actuals	25,020	23,480	21,922	21,562	22,885	22,677	19,509	20,541	18,944	21,194	19,811	17,218	253,864
Net R&D	33,173	31,892	33,006	31,998	33,048	35,202	30,206	32,408	31,039	30,498	31,928	30,969	385,367
Current Calendarization													
2000 Final AGU	32,133	30,404	35,911	33,138	32,858	45,704	28,013	27,124	28,385	27,095	27,115	27,512	374,730
2000 Actuals	32,133	30,404	35,911	33,138	32,858	45,704	28,013	27,124	28,385	27,095	27,115	27,512	375,590
2001 Quarterly Profile	100	200	300	400	500	600	700	800	900	1,000	1,100	1,200	1,300
2001 PLAN (12/08/00)	99,071	100,248	93,653	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395
Blue Plan	0	0	0	0	0	0	0	0	0	0	0	0	0
Changes	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
TBD	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (DIP)	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Expected PLAN	99,071	100,248	93,653	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395	93,395
Expected PLAN	0	0	0	0	0	0	0	0	0	0	0	0	0

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ABB# 0037532

PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
2001 PLAN
GLOBAL AI CALENDARIZATION

02/18/01
09:37 AM

Global AI
Total Fixed AI
Total Direct AI
Total AI Support
Total Global

JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
10,385	15,435	16,074	15,548	15,835	17,193	14,280	15,224	14,922	14,798	15,574	15,214	186,570
189	189	189	189	189	189	189	189	189	189	189	185	2,384
317	317	317	317	317	317	317	317	317	317	317	313	3,800
516	516	516	516	516	516	516	516	516	516	516	508	6,184
16,001	15,851	16,590	16,062	16,451	17,699	14,795	15,740	15,438	15,314	16,180	15,722	192,854
10,645	14,364	14,789	14,474	16,424	17,281	17,869	15,360	19,401	19,301	16,441	15,581	182,040

2000 AGU Global AI

HIGHLY
CONFIDENTIAL
ABBT 0037533

21

PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS MONTH - \$
2001 PLAN

02/19/01
00:57 AM

TOTAL FIXED AND DIRECT CHARGES	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 378)	14,970	1,248	1,248	1,248	1,248	1,248	1,248	1,248	1,248	1,248	1,248	1,248	1,242	14,970
Macrolide (ABT 773)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) Pediatric	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) LV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cholinergic Channel Modulator	---	---	---	---	---	---	---	---	---	---	---	---	---	---
BPH Backup	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Endothelin	683	57	57	57	57	57	57	57	57	57	57	57	56	683
NPS-1776	490	41	41	41	41	41	41	41	41	41	41	41	39	490
Quinolone	5,762	480	480	480	480	480	480	480	480	480	480	480	482	5,762
Cancer - Anti Mitotic (Elsai-7010)	1,172	98	98	98	98	98	98	98	98	98	98	98	94	1,172
Clari 140H	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cancer - Angiogenesis	2,753	229	229	229	229	229	229	229	229	229	229	229	234	2,753
Clari IV	4,297	358	358	358	358	358	358	358	358	358	358	358	359	4,297
Clari Process Improvements	1,700	142	142	142	142	142	142	142	142	142	142	142	138	1,700
New Products	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Process Impv (ery Danisco)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Pass Through	31,827	2,653	2,653	2,653	2,653	2,653	2,653	2,653	2,653	2,653	2,653	2,653	2,644	31,827
DISCOVERY														
Natural Products Discovery	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Patents & Trademarks	370	31	31	31	31	31	31	31	31	31	31	31	29	370
Miscellaneous (Depr adjusted here)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Discovery Special Labs	2,621	218	218	218	218	218	218	218	218	218	218	218	223	2,621
Subtotal Discovery	2,991	249	249	249	249	249	249	249	249	249	249	249	252	2,991
OTHER														
Dom Other-Ery Proc Imp	369	31	31	31	31	31	31	31	31	31	31	31	28	369
Global Other - Clari I	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Clari IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - ABT 378 IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc PMP	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc (Add'l Warehou	23	2	2	2	2	2	2	2	2	2	2	2	1	23
Protease 2nd Gen to PPNC	---	---	---	---	---	---	---	---	---	---	---	---	---	---
New Projects	5,390	449	449	449	449	449	449	449	449	449	449	449	451	5,390
New Projects	1,225	102	102	102	102	102	102	102	102	102	102	102	103	1,225
Excess Capacity	11,610	968	968	968	968	968	968	968	968	968	968	968	962	11,610
Unit of Activity Charges	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other-Misc. MJH Adjust	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Total SPD	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435
				13,362			13,362			13,362			13,349	

EXPORT PLAN 000001 PLAN 0001 PLAN 0002 PLAN

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ABBT 0037534

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - \$
2001 PLAN

02/18/01
08:37 AM

TOTAL FIXED AND DIRECT CHARGES	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 378)	14,970	1,248	2,486	3,744	4,992	6,240	7,488	8,736	9,984	11,232	12,480	13,728	14,970	14,970
Macrolide (ABT 773)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) Pediatric	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) I.V.	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cholinergic Channel Modulator	---	---	---	---	---	---	---	---	---	---	---	---	---	---
BPH Backup	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Endothelin	683	57	114	171	228	285	342	399	456	513	570	627	683	683
NPS-1776	480	41	82	123	164	205	246	287	328	369	410	451	490	490
Quinolone	5,762	480	960	1,440	1,920	2,400	2,880	3,360	3,840	4,320	4,800	5,280	5,762	5,762
Cancer - Anti Mitotic (Elsal-7010)	1,172	98	196	294	392	490	588	686	784	882	980	1,078	1,172	1,172
Clari 14OH	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cancer - Angiogenesis	2,753	229	458	687	916	1,145	1,374	1,603	1,832	2,061	2,290	2,519	2,753	2,753
Clari IV	4,297	358	716	1,074	1,432	1,790	2,148	2,506	2,864	3,222	3,580	3,938	4,297	4,297
Clari Process Improvements	1,700	142	284	426	568	710	852	994	1,136	1,278	1,420	1,562	1,700	1,700
New Products	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Process Impv (ery Danisco)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Pass Through	31,827	2,653	6,306	7,959	10,612	13,265	15,918	18,571	21,224	23,877	26,530	29,183	31,827	31,827
DISCOVERY														
Natural Products Discovery	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Patents & Trademarks	370	31	62	93	124	155	186	217	248	279	310	341	370	370
Miscellaneous (Depr adjusted here)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Discovery Special Labs	2,621	218	436	654	872	1,090	1,308	1,526	1,744	1,962	2,180	2,398	2,621	2,621
Subtotal Discovery	2,991	249	498	747	996	1,245	1,494	1,743	1,992	2,241	2,490	2,739	2,991	2,991
OTHER														
Dom Other-Ery Proc Imp	389	31	62	93	124	155	186	217	248	279	310	341	389	389
Global Other - Clari I	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Clari IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - ABT 378 IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc PMP	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc (Add'l Warehou	23	2	4	6	8	10	12	14	16	18	20	22	23	23
Protease 2nd Gen to PPNC	---	---	---	---	---	---	---	---	---	---	---	---	---	---
New Projects	5,390	449	898	1,347	1,798	2,249	2,694	3,143	3,592	4,041	4,490	4,939	5,390	5,390
New Projects	1,225	102	204	306	408	510	612	714	816	918	1,020	1,122	1,225	1,225
Excess Capacity	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Unit of Activity Charges	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other-Misc. MJH Adjust	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435

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ABBT 0037535

23

PPPD SERVICES PURCHASED - SPD
RECONCILIATIONS MONTH - 8
2001 PLAN

SEPTEMBER
10 07 AM

FIXED CHARGES	01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 378)	5,502	454	454	454	454	454	454	454	454	454	454	454	454	5,502
Macrolide (ABT 773)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) Pediatric	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) I.V.	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cholinergic Channel Modulator	---	---	---	---	---	---	---	---	---	---	---	---	---	---
BPH Backup	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Endothelin	490	41	41	41	41	41	41	41	41	41	41	41	41	490
NPS-1776	490	41	41	41	41	41	41	41	41	41	41	41	41	490
Quinolone	3,302	280	280	280	280	280	280	280	280	280	280	280	280	3,302
Cancer - Anti Mitotic (Elsal-7010)	937	76	76	76	76	76	76	76	76	76	76	76	76	937
Clarl 140H	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cancer - Angiogenesis	2,085	174	174	174	174	174	174	174	174	174	174	174	174	2,085
Clarl IV	1,225	102	102	102	102	102	102	102	102	102	102	102	102	1,225
Clarl Process Improvements	748	62	62	62	62	62	62	62	62	62	62	62	62	748
New Products	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Process Impr (any Danisco)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Pass Through	14,869	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	14,869
DISCOVERY														
Natural Products Discovery	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Patents & Trademarks	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Miscellaneous (Depr adjusted here)	2,021	218	218	218	218	218	218	218	218	218	218	218	218	2,021
Discovery Special Labs	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Discovery	2,021	218	218	218	218	218	218	218	218	218	218	218	218	2,021
OTHER														
Dom Other-Ery Proc Imp	389	31	31	31	31	31	31	31	31	31	31	31	31	389
Global Other - Clarl I	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Clarl IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - ABT 378 IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc PMP	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc (Add'l Warehouse)	23	2	2	2	2	2	2	2	2	2	2	2	2	23
Protease 2nd Gen to PPNC	5,390	448	448	448	448	448	448	448	448	448	448	448	448	5,390
New Projects	1,225	102	102	102	102	102	102	102	102	102	102	102	102	1,225
Excess Capacity	11,010	908	908	908	908	908	908	908	908	908	908	908	908	11,010
Unit of Activity Charges	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other-Misc. MUH Adjust	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Total SPD Fixed Charges	35,107	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	3,010	35,107
DIRECT CHARGES														
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 378)	9,408	784	784	784	784	784	784	784	784	784	784	784	784	9,408
Macrolide (ABT 773)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) Pediatric	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Macrolide (ABT 773) I.V.	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cholinergic Channel Modulator	---	---	---	---	---	---	---	---	---	---	---	---	---	---
BPH Backup	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Endothelin	193	16	16	16	16	16	16	16	16	16	16	16	16	193
NPS-1776	2,400	200	200	200	200	200	200	200	200	200	200	200	200	2,400
Quinolone	265	22	22	22	22	22	22	22	22	22	22	22	22	265
Cancer - Anti Mitotic (Elsal-7010)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Clarl 140H	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Cancer - Angiogenesis	668	55	55	55	55	55	55	55	55	55	55	55	55	668
Clarl IV	3,072	256	256	256	256	256	256	256	256	256	256	256	256	3,072
Clarl Process Improvements	952	80	80	80	80	80	80	80	80	80	80	80	80	952
New Products	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Misc Process Impr (any Danisco)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Pass Through	18,958	1,413	1,413	1,413	1,413	1,413	1,413	1,413	1,413	1,413	1,413	1,413	1,413	18,958
DISCOVERY														
Natural Products Discovery	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Patents & Trademarks	370	31	31	31	31	31	31	31	31	31	31	31	31	370
Miscellaneous (Depr adjusted here)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Discovery Special Labs	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Subtotal Discovery	370	31	31	31	31	31	31	31	31	31	31	31	31	370
OTHER														
Dom Other-Ery Proc Imp	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Clarl I	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Clarl IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - ABT 378 IV	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc PMP	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other - Misc (Add'l Warehouse)	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Protease 2nd Gen to PPNC	---	---	---	---	---	---	---	---	---	---	---	---	---	---
New Projects	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Excess Capacity	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Unit of Activity Charges	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Global Other-Misc. MUH Adjust	---	---	---	---	---	---	---	---	---	---	---	---	---	---
Total SPD Direct Charges	17,328	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	17,328

LEGACY PLANING FOR 2001 PLAN 01/28/2008

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - \$
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FIXED CHARGES	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 370)														
Macrolide (ABT 773)	5,562	464	628	1,392	1,658	2,320	2,784	3,248	3,712	4,176	4,640	5,104	5,562	5,502
Macrolide (ABT 773) Pediatric														
Macrolide (ABT 773) I.V.														
Cholinergic Channel Modulator														
BPH Backstop														
Endothelin	490	41	82	123	164	205	246	287	328	369	410	451	490	490
NPS-1776	490	41	82	123	164	205	246	287	328	369	410	451	490	490
Quinolone	3,362	280	560	840	1,120	1,400	1,680	1,960	2,240	2,520	2,800	3,080	3,362	3,362
Cancer - Anti Mitotic (Eisai-7010)	907	76	152	228	304	380	456	532	608	684	760	836	907	907
Clari 140H														
Cancer - Angiogenesis	2,085	174	348	522	696	870	1,044	1,218	1,392	1,566	1,740	1,914	2,085	2,085
Clari IV	1,225	102	102	102	102	102	102	102	102	102	102	102	102	1,225
Clari Process Improvements	748	62	62	62	62	62	62	62	62	62	62	62	62	748
New Products														
Misc Process Impr (w/ Danisco)														
Subtotal Pass Through	15,617	1,302	2,440	3,576	4,710	5,854	6,992	8,130	9,268	10,406	11,544	12,682	14,014	14,014

DISCOVERY

Natural Products Discovery														
Patents & Trademarks														
Miscellaneous (Depr adjusted here)														
Discovery Special Labs	2,621	210	430	654	872	1,090	1,308	1,526	1,744	1,962	2,180	2,398	2,621	2,621
Subtotal Discovery	2,621	210	430	654	872	1,090	1,308	1,526	1,744	1,962	2,180	2,398	2,621	2,621

OTHER

Dom Other-Ery Proc Imp	368	31	62	93	124	155	186	217	248	279	310	341	369	369
Global Other - Clari I														
Global Other - Clari IV														
Global Other - ABT 370 IV														
Global Other - Misc PMP														
Global Other - Misc (Add'l Warehouse)	23	2	4	6	8	10	12	14	16	18	20	22	23	23
Protease 2nd Gen to PPNC														
New Projects	5,390	448	896	1,347	1,796	2,245	2,694	3,143	3,592	4,041	4,490	4,939	5,390	5,390
Excess Capacity	1,225	102	102	102	102	102	102	102	102	102	102	102	102	1,225
Unit of Activity Charges	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Global Other-Misc, MJH Adjust														
Total SPD Fixed Charges	35,855	3,072	5,980	8,888	11,796	14,704	17,612	20,520	23,428	26,336	29,244	32,152	35,252	35,252

DIRECT CHARGES

	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
PASS THROUGH CHARGES:														
Protease 2nd Gen (ABT 370)														
Macrolide (ABT 773)	9,408	784	1,568	2,352	3,136	3,920	4,704	5,488	6,272	7,056	7,840	8,624	9,408	9,408
Macrolide (ABT 773) Pediatric														
Macrolide (ABT 773) I.V.														
Cholinergic Channel Modulator														
BPH Backstop														
Endothelin	193	16	32	48	64	80	96	112	128	144	160	176	193	193
NPS-1776														
Quinolone	2,400	200	400	600	800	1,000	1,200	1,400	1,600	1,800	2,000	2,200	2,400	2,400
Cancer - Anti Mitotic (Eisai-7010)	265	22	44	66	88	110	132	154	176	198	220	242	265	265
Clari 140H														
Cancer - Angiogenesis	688	55	110	165	220	275	330	385	440	495	550	605	660	688
Clari IV	3,072	256	512	768	1,024	1,280	1,536	1,792	2,048	2,304	2,560	2,816	3,072	3,072
Clari Process Improvements	952	80	160	240	320	400	480	560	640	720	800	880	952	952
New Products														
Misc Process Impr (w/ Danisco)														
Subtotal Pass Through	19,958	1,413	2,826	4,239	5,652	7,065	8,478	9,891	11,304	12,717	14,130	15,543	16,956	16,956

DISCOVERY

Natural Products Discovery														
Patents & Trademarks	370	31	62	93	124	155	186	217	248	279	310	341	370	370
Miscellaneous (Depr adjusted here)														
Discovery Special Labs														
Subtotal Discovery	370	31	62	93	124	155	186	217	248	279	310	341	370	370

OTHER

Dom Other-Ery Proc Imp														
Global Other - Clari I														
Global Other - Clari IV														
Global Other - ABT 370 IV														
Global Other - Misc PMP														
Global Other - Misc (Add'l Warehouse)														
Protease 2nd Gen to PPNC														
New Projects														
Excess Capacity														
Unit of Activity Charges														
Global Other-Misc, MJH Adjust														
Total SPD Direct Charges	17,328	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328	17,328

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS MONTH - \$
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	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SUMMARY SPD														
Total Pilot Plant/PMP Stock Card	24,497	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,042	2,035	24,497
Total Bulk Drug Direct	17,328	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	1,444	17,328
Total Excess Capacity Stock Card	11,610	968	968	968	968	968	968	968	968	968	968	968	962	11,610
Total SPD	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435
SUMMARY GLOBAL/DOMESTIC														
Total Global SPD	47,069	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,923	3,916	47,069
Total All Other Domestic SPD	6,366	531	531	531	531	531	531	531	531	531	531	531	525	6,366
Total SPD	53,435	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,454	4,441	53,435

KEY CHECK (S/B D) ->

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PPRD SERVICES PURCHASED - SPD
RECONCILIATIONS YTD - \$
2001 PLAN

	'01 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SUMMARY SPD														
Total Pilot Plant/PMP Stock Card	24,497	2,042	4,084	6,126	8,168	10,210	12,252	14,294	16,336	18,378	20,420	22,462	24,497	24,497
Total Bulk Drug Direct	17,328	1,444	2,888	4,332	5,776	7,220	8,664	10,108	11,552	12,996	14,440	15,884	17,328	17,328
Total Excess Capacity Stock Card	11,610	968	1,936	2,904	3,872	4,840	5,808	6,776	7,744	8,712	9,680	10,648	11,610	11,610
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435
SUMMARY GLOBAL/DOMESTIC														
Total Global SPD	47,069	3,923	7,846	11,769	15,692	19,615	23,538	27,461	31,384	35,307	39,230	43,153	47,069	47,069
Total All Other Domestic SPD	6,366	531	1,062	1,593	2,124	2,655	3,186	3,717	4,248	4,779	5,310	5,841	6,366	6,366
Total SPD	53,435	4,454	8,908	13,362	17,816	22,270	26,724	31,178	35,632	40,086	44,540	48,994	53,435	53,435

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PPRD AFFORDABILITY
RECONCILIATIONS MONTH - \$
2001 PLAN

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	2001 PLAN	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
SDG/Other	***	***	***	***	***	***	***	***	***	***	***	***	***	***
HIV/Knoll/QD/Other	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Aegis Insurance	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Genset #1	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Genset #2	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Neurosearch FTE \$2530, depr \$200	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Coaclonon	***	***	***	***	***	***	***	***	***	***	***	***	***	***
SPD IDV Liponavir	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Thrombolytics to HPD (Ovrhd & Grants)	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Data Management Absorption	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Other New Products	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Quinolone Payment	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Division Task	***	***	***	***	***	***	***	***	***	***	***	***	***	***
Total SDG/Other	***	***	***	***	***	***	***	***	***	***	***	***	***	***

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Key Issues in 2001

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Final

**Pharmaceutical Research & Development
Key Plus/Minus List
2001
(\$MM's)**

Description	Commentary	Probability	Fav/Unfav
DPI Agreement	Licensing agreement with Discovery Partners International. Accounting to be clarified with Corporate.	High	2.0
SPD Bulk drug for Ketolide	Discussions are currently on-going with SPD to drop the number of bulk manufacturing campaign runs from 6 to 4 for the April Update.	High	1.5 - 2.0
Kelaira FDA Strategy	The current Kelaira budget assumes all data that is scheduled to be submitted as part of the FDA Accelerated Approval timetable will be sufficient. In the event that the data is inconclusive (as determined by the FDA) additional dollars will be needed to continue existing studies.	High	(1.2)
Subtotal for High Probability Scenarios			
2.3 - 2.8			
CCM Milestone Funding	Go/No go decision is scheduled for May/June 2001. If the decision to continue development is made, additional funding will be needed to continue the program.	Medium	(6.5)
Ketolide Japan	Japan Phase III studies have been milestones funded. If positive data is available in the 4Q (this is the projected start date of the study), funding will be needed to stay on target with the expeditions of Japan regulators.	Medium	(4.0)
Quinolone Milestone Payment	Currently, Phase III milestones payment is unbudgeted. If current enrollment levels are achieved for Phase III, additional funding will be necessary to satisfy our contractual obligations. There is a high probability that the contract will be re-negotiated and the milestones payment will then come due in 1Q 2002.	Medium	(3.5)
Subtotal for Medium Probability Scenarios			
(17.3)			
Immunosuppressant Sale	Sale of this compound is expected in 2001. Global Pharmaceutical R&D Division could potentially receive the revenue from this sale.	Low	6.0
Karo Bio DDC	If Karo Bio does not produce a DDC, we will not owe them a milestone payment in 2001.	Low	1.0
Binoclonol Funding	Go/No go decision is expected in late 1Q or early 2Q 2001. If the decision to continue development is made, Phase III studies will require funding.	Low	(11.7)
Subtotal for Low Probability Scenarios			
(5.7)			

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2001 PLAN
PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT

	In	Out
NEUROLOGY		
Depakote	<ul style="list-style-type: none"> - On going activities: elderly agitation, impulsive aggression, psychosis - New activities: polyovulatory ovary, new DR form, 20mg ER definitive b1a 	<ul style="list-style-type: none"> - New formulations: epilepsy & migraine - Bipolar in pediatric needs - Dose Proportionality - Pediatric Fentanyl Extension - Psych - Acute Migraine - Depakote Status Epilepticus
ABT-594	<ul style="list-style-type: none"> - Milestone funded to Go/No Go decision June 2001 for neuropathic pain 	<ul style="list-style-type: none"> - Funding for Std and 4th qtr # Go decision is made - Phase IIB Chronic Persistent Pain
COX - II	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Continuation of pre clinical and Phase I studies
ABT-088	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Single/Multiple rising dose Ph I study
ABS-103	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Pre clinical studies - Single rising dose Ph I study
NPS-1778	<ul style="list-style-type: none"> - Completion of work started in 2000 bringing it to a logical stopping point 	<ul style="list-style-type: none"> - Pre clinical studies - Single and stagger multiple dose Ph I study and formulation bio studies
Hydrocodone/bupropion	<ul style="list-style-type: none"> - Rapid dissolve and controlled release forms 	
ANTI-INFECTIVE		
Clarithromycin	<ul style="list-style-type: none"> - Extended Release Once/Day - Phase IV ind 	<ul style="list-style-type: none"> - Cysto Fibrosis - Asthma
Keritide	<ul style="list-style-type: none"> - Tablet: FDA delayed review forcing ABT to add new sites and redo tissue studies to maintain NDA filing date. Cost = \$4.5MM - Drug Interaction studies: Warfarin, Digoxin & Gabapentin #17 	<ul style="list-style-type: none"> - IV - Pediatric - Japan Ph II/III - Drug Interaction studies: Lorazepam, Carbamazepine & Cyclosporine
Quinolone	<ul style="list-style-type: none"> - Tablet - \$3MM milestones payment for Initiating Ph IIA 	<ul style="list-style-type: none"> - Milestone payment for initiation of Ph IIB \$3.5MM
Neuraminidase (ABT-677)		<ul style="list-style-type: none"> - 2 week toxicology study - single rising dose study - multiple rising dose study
Omnicef	<ul style="list-style-type: none"> - Oritis Media 	<ul style="list-style-type: none"> - AECB & Pharyngitis

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UROLOGY/NEUROLOGY**Fenofibrate (Fountain)**

	In	Out
KCO	- Pre Clinicals	- Diabetes - PH Women - Feno Post MI
HIV		
Ritonavir	- Norvir / Ralte Combo - Efficacy & B	
Kaletra	- IBHSC/Aradex - Kroll (SEC reformulation) - HAAST Metabolic complications - Burs Phase III B Switch & Efficacy - Expanded Access - PH II Pediatric - PH III Naïve	- Current assumption is that long term safety data from completed portion of PH II Pediatric and PH III Naïve studies will suffice for FDA requirements. If the FDA requires us to finish those studies we will need about \$1.2MM.
Cyclosporine	- PREFER - European Switch Kidney Plus Extension - Pediatric PK	
CANCER		
Erdafitinib (ABT-827)	- PH II pivotal study #1 - Initiate PH III pivotal study #2 - CTC - Bioequivalence - Drug Interaction studies: Fexofenadine	- Early Stage Post - PH II explorations - Drug Interaction studies: Midazolam, Ketorolac & Fentanyl
TSP #1 (ABT-810)	- Multiple dose in cancer patients - IND study	- Manufacturing & Toxicology
Metformin	- Multiple dose in cancer patients - IND study	- Manufacturing & Toxicology
Anti-Mitotic (ABT-751)	- Multiple dose in cancer patients - IND study	- Pre clinical / PH I studies
K-6		- Pre clinical / PH I studies
FTI #2		- DDC's & In - licensing
Other New Products		- ADF, Exploratory, AEGIS Meds, productivity projects
Other		- Elmodinol
Discovery		- Geneset

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Discovery
ABT-963
2001 PLAN KEY STATISTICS Phase II
(\$000)

Project	2001 Target	2000 AGU	2001 PLAN	Target vs PLAN Pay(Unfav) Var
Cox II Inhibitor	1,200	4,000	1,186	14

Key Milestones / Assumptions	00 AGU 12/2000 2/2001	01 PLAN 12/2000 2/2001	Status (on target, pending or delayed in 2)
Initiate Phase I SD Study			
Beyond Phase I SD Go/No Go Decision			

PAID	00 AGU 12/2000 2/2001	01 PLAN 12/2000 2/2001
Analytics Dev & Support	195	21
Formulation Dev & Support	147	11
Clinical Finishing	33	18
Project Management Support	29	--
PARD Total	404	50

Total Venture Management	00 AGU 12/2000 2/2001	01 PLAN 12/2000 2/2001
Cox II is presently not assigned to a venture and managed by Dr. George Carter in Discovery		

Clinical Grants	00 AGU 12/2000 2/2001	01 PLAN 12/2000 2/2001
Phase I M00-238		

Phase I	00 AGU 12/2000 2/2001	01 PLAN 12/2000 2/2001
Single Dose (Europe)		

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Total

2001 PLAN

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Amalgasia Venture
ABS-103
2001 PLAN KEY STATISTICS Pass II
(\$000)

Project	2001 Target	2000 AGU	2001 PLAN	Target vs PLAN For (Unfav) Var
ABS - 103 (Unfunded)	---	---	---	---
Key Milestones / Assumptions				
- DDC Meeting		00 AGU	01 PLAN 4/2001	Status (on target, pending or delayed to)
-				
-				
-				
-				
-				
PARD				
- Analytics Dev & Support		00 AGU	01 PLAN	
- Formulation Dev & Support		---	---	
- Clinical Finishing		---	---	
- Project Management Support		---	---	
- PARD Total		---	---	
Total Venture Management				
- Expenses: \$3,988, reflecting milestones funding				
- Authorized Heads: Flat to AGU until July, 2001, ABT-594, Go/No Go Decision, then 11 headcount after July, 2001				
SPD Requirements				
	Kpi	Heads	Mat Cont	Total Cont
2000 AGU	---	---	---	---
2001 PLAN	---	---	---	---
Clinical Grants				
	In Patient Dosed	Last CRF	R/oss 2000 AGU	Cost
	Start	End	Start	End
			2001 PLAN	
			Total	00 AGU 01 PLAN Variance

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Total

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**Analgesia Venture
NPS 1776
2001 PLAN KEY STATISTICS Pass II
(\$000)**

Project	2001	2000	2001	Target vs PLAN	
	Target	AGU	PLAN	Pay(Unfav)	Var
NPS-1776 (Unfunded)	500	...	537	(37)	
Key Milestones / Assumptions					
• DDC Meeting					
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**ANTHINFECTIVE FRANCHISE
CLARITHROMYCIN
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 AGU	2001 Plan	2001 PLAN Fav(Unl) vs. AGU
Extended Release Once/Day	10,688	3,485	5,223
Pediatric New Strength (N14C)	107	41	66
XL/MR Patent Protection world wide (PARD/DOC)	883	152	731
AI Pediatric	4,573	30	4,543
Phase IV Int.	3,091	9,395	(6,304)
AI 1 Gram Tablet	2,885	11	2,874
Japan 400MG Tablet	1,891	0	1,891
Other	2,105	594	1,525
Total Clarithromycin	28,317	14,576	10,539
Plan Target	28,400	14,500	(11,500)
Variance Fav(Unl) vs. target	83	(776)	(651)

Key Milestones / Assumptions	'00 AGU	'01 PLAN	Status
Extended Release Once/Day			
• Initiate BAL study Label addition for Biaxin XL	~	8/00	Complete
• Initiate Mucolytic-Private IND Studies (Investig. Initiated)	~	9/00	Complete
• Initiate Immunomodulatory Program - Private IND Studies (Investig. Initiated)	~	9/00	Complete
• Initiate Pertussis study (Investigator Initiated)	~	TBD	Complete
PARD			
• Patent protection effort for XL and MR formulations	1/00	9/01	Ongoing
Budget (\$000)			
• Analytical Development & Support	AGU	2001 PLAN	2001 vs AGU Fav(Unl)
• Formulation Development & Support	679	335	644
• Clinical Finishing	2,061	231	1,830
• Project Mgt.	290	350	(59)
• Total	3,029	137	183
	3,559	1,001	2,498

Vendor Management (Total Payments)
• Exposed:
• \$12,829M (Increase of \$3,644M vs 2000 Actual; Includes ART-482 Milestone payment of \$3MM, \$1MM Milestone Payment)
• Total Heads - 81, unchanged vs. AGU. Abbott N14 New - 31, unchanged vs. AGU.

CAP Requirements				
AGU	Kos	Heads	Multi Cost	Total Cost
2001	0	0	326	326 A
2001	0	0	0	0

A) Project budget does not include Phase IV bulk drug development expense (process improvement) of \$4.7MM; \$326M included in AGU for 14-OH metabolite.

		1st Patient Dosed	Last CRF	R/OSS 2000 AGU	R/OSS 2001 PLAN	Study Total	Cost (\$000)	2001 Fav(Unl) vs. AGU
				Start	End	Start	End	
Domestic Studies								
Accrual Adjustments - Completed Studies								
Extended Release Once/Day								
M89-066	Biaxin XL vs. Augmentin in AECB (300 pts)	9/99	4/00	9/99	4/00	3,900	1,277	0
M99-077	Biaxin XL vs. Levofloxacin in CAP (replace Trova 300 pts)	9/99	7/00	9/99	7/00	4,000	2,333	0
M99-083	Biaxin XL + Ceph. IV Step Down study vs Lev. (160 pts)	1/00	12/00	1/00	12/00	500	357	500
M99-086B	Biaxin XL Immunomodulatory Study	1/00	12/00	1/00	12/00	500	527	0
M00-205	Biaxin XL Mucolytic-Private IND Studies (Inv. Init.; 30 pts.)	8/00	12/01	8/00	12/01	180	0	180
M00-208	Biaxin XL Mucolytic-Private IND Studies (Inv. Init.; 60 pts.)	9/00	12/01	9/00	12/01	180	0	180
M00-207	Biaxin XL Immunomodulatory - Private (Inv. Init. pat. TB)	3/00	12/02	3/00	12/01	880	0	880
* Note: M00-205, M00-207, M00-208 continuations of M99-066B								
M00-214	BAL study Label addition for Biaxin XL (45 patients)	8/00	4/01	8/00	4/01	350	350	0
TBD	Pertussis Investigator Initiated study (patients TBD)	TBD	TBD	TBD	TBD	150	0	150
N/A	Counter Resistance - Animal In Vivo studies CAP registry	N/A	N/A	N/A	N/A	500	0	1,050

2001 PLAN TOTAL: 28,400 AGU, 14,500 PLAN, 10,500 FAV, 11,500 VAR

International								
W99-317	PRSP/DRSP IR	11/99	8/00	11/99	8/00	3,249	2,500	749
Pediatric (International)								
Multiple	AI Ped Once-A-Day	1/00	12/02	1/00	12/02	6,707	1,300	0
Other (International)								
Multiple	AI 1 Gram PK Studies	1/00	12/02	1/00	12/02	2,780	850	0
Multiple	AI Japan 400MG Tablet	1/00	12/02	1/00	12/02	3,488	1,033	0
Multiple	Cart MR	1/01	12/01	1/01	12/01	0	0	0
Multiple	Cart CD XL vs. MR	4/00	12/02	4/00	12/02	9,056	680	5705
MECAPP								
Italy Whizzo (Included in Domestic - Immunomodulatory)							0	848
							0	0

2001 PLAN TOTAL: 28,400 AGU, 14,500 PLAN, 10,500 FAV, 11,500 VAR

2001 PLAN TOTAL: 28,400 AGU, 14,500 PLAN, 10,500 FAV, 11,500 VAR

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ANTI-INFECTION FRANCHISE
Ketolide ABT-773
2001 PLAN KEY STATISTICS
(000)

Project	2000 Actual	2001 PLAN	2001 PLAN vs. '00 Actual
KETOLIDE ABT-773	67,887	66,576	1,311
Tablet	2,582	0	2,582
Pediatric	2,837	1,828	1,009
Japan Formulation/Registration	1,000	84	916
IV	74,328	66,274	8,054
Target	74,100	66,200	7,900
Variance Fed(Ind) vs. Target	(428) A	(2,274) B	(1,846)

A) Unshaded IV Project responsible for variance from target.
B) Variance expected to be reduced in APD by reduction of one SPD bulk drug campaign (\$1,000M) and reduction in international support to Japan registration (\$1.4MM).
C) Japan Registration estimate for 2001 assumes delay in Phase III studies in 2002.

Key Milestones / Assumptions	00 AGU	01 PLAN	Comments
Complete Phase III	6/00	6/00	Complete
End of Phase II - FDA Meeting	10/00	12/00	Complete, Protocol changes will delay Europe start.
Initiate Phase II - North America / Europe	11/00	11/00	Phase II delayed; Studies will start 6Q 00, Europe 1Q 01
Initiate Phase II - South Africa / South America	4/01	4/01	Additional sites to achieve required patients by NDA filing date
Pediatric Formulation Co / No-Co	8/00	11/00	No funding for Pediatric in 2001.
SPD Bulk Drug: (Year 2001: 5 deliveries of 333KG @ \$1,616KG Total)	10/1-12/01	10/1-12/01	Discussing with SPD the possibility for reduction of some delivery
Initiate Phase III CAP / Shuntan comparator studies	8/01	11/01	On target (Based on CAP / Shuntan 150mg QD vs. 150mg BID results).
File Tablet NDA	8/02	8/02	NDA filing delayed to 3Q 2002
File Pediatric and IV NDAs	TBD	TBD	No funding for Pediatric or IV in 2001 Plan.

FAHD	00 AGU	01 PLAN	Status (on target, pending or delayed to)
Scale Up activities 75L	6/99-1/00	6/99-1/00	Complete
Intermediate scale up 300L	12/99-2/00	12/99-2/00	Complete

Budget	2001	1999	2001 Plan vs. AGU Fed(Ind)
Analytical Development & Support	2,061	1,723	338
Formulation Development & Support	2,223	1,456	767
Clinical Financing	1,845	1,478	367
Project Mgt.	647	567	80
Total	6,776	5,224	1,552

Vendor Management

Expense:
\$12,020M (Increase of \$3,504M vs 2000 Actual; includes ABT-402 Milestone payment of \$2MM).

Total Heads - 41, unchanged vs. AGU. Abbott full time - 38, unchanged vs. AGU.

2000 AGU	2001 PLAN	2001 PLAN vs. AGU Fed(Ind)
2,515	2,215	300
1,875	1,875	0

A) 2150 Kgs for Tablet Formulation, 242 Kgs for Pediatric, 80 Kgs for IV @ \$7,500/Kg.
Total CAPD costs include headcount related charges of \$7,425K.
B) 2,510 Kgs @ \$7,500/Kg for \$18,825K less net prepaying \$2.1MM. (\$6,667/Kg net of bulk).
C) 1,875 Kgs @ \$5,000/Kg = headcount and prepaying charges of \$9,375K. Does not reflect planned reduction of one bulk drug campaign.

	1st Patient Dosed	Last CRF	ROSS 2000 AGU		ROSS 2001 PLAN		Study Total	Cost(000)		2001 Plan(Units) vs. AGU	
			Start	End	Start	End		2000 AGU	2001 PLAN		
ACPRU STUDIES (Initiated in 2001)											
Bio 300L = 1200L	5-01				5-01	12-01	216		216	(216)	
Bio 300L=600L US	11-01				11-01	6-02	231		231	(231)	
Drug Interaction Lorazepam - (delayed to 2002)	TBD				TBD	TBD	175				
Drug Interaction Warfarin	3-01				3-01	8-01	214		214	(214)	
Drug Interaction Digoxin	1-01				1-01	7-01	372		372	(372)	
Drug Interaction Carbamazepine (delayed to 2002)	TBD				TBD	TBD	215				
Drug Interaction Cyclosporin (delayed to 2002)	TBD				TBD	TBD	290				
Drug Interaction Celestic #17	10-01				10-01	10-02	162		162	(162)	
ABT-773 Site 6SL in 300L	5-01				5-01	10-01	175		175	(175)	
ACPRU Total New 2001 Studies								1,370		(1,370)	
PHASE II STUDIES											
M99-054 CAP	9-99	6/00	9-99	6/00	9-99	6/00	4,089	1,637	--	1,637	
M99-053 Shuntan	9-99	6/00	9-99	6/00	9-99	6/00	3,172	1,556	--	1,556	
M99-048 AECB	9-99	6/00	9-99	6/00	9-99	6/00	3,863	2,212	--	2,212	
Writing							210	157	--	157	
								11,234	4,564	--	4,564
TOTAL PHASE II STUDIES											
2000 External Bio Studies											
M99-119 Japan Phase I	12/99	4/00	12/99	4/00	12/99	4/00	857	790	--	790	
M99-142 Tissue Studies	3/00	12/00	3/00	12/00	3/00	12/00	463	409	--	409	
Tissue Study - Cont'd - 150mg	3/01	12/01			3/01	12/01	500	--	500	(500)	
Tissue Study - Gated - 150mg QD vs. 150mg BID	3/01	12/01			3/01	12/01	500	--	500	(500)	
Renal	8/00	2/01	8/00	2/01	8/00	2/01	300	69	135	(89)	
Hepatic	3/00	3/01	3/00	3/01	3/00	3/01	313	251	62	189	
								2,333	1,579	1,200	379
JAPAN STUDIES (New Formulation)											
Japan Phase I	10/00	3/01	10/00	3/01	10/00	3/01	1,800	1,800	--	1,800	
Japan Phase III							22,000		--		
								23,800	1,800	--	1,800
PHASE III STUDIES											
Multiple	6/00	6/00	6/00	6/00	6/00	6/00	1,306	1,306	--	1,306	
M00-221 (M99-089) CAP - Levo 500mg QD, N/ASA (450 pat.)	6/01	3/02	6/01	3/02	11/01	5/02	4,200	--	2,343	(2,343)	
M00-218 (M00-152) CAP - Open Label NA (500 pat.)	11/00	6/01	11/00	6/01	11/00	6/01	10,288	3,535	12,771	(9,186)	
M00-220 (M00-151) CAP - Amoxicillin + Az. EU (500 pat.)	6/01	3/02	6/01	3/02	11/01	5/02	5,700	--	1,623	(1,623)	
M00-226 (M00-143) Shuntan - Celestic 240mg BID, NA (150 pat.)	6/01	3/02	6/01	3/02	11/01	5/02	4,400	--	1,257	(1,257)	
M00-225 (M00-097) Shuntan - Open Label, NA, SA, EU (500 pat.)	11/00	6/01	11/00	6/01	11/00	6/01	6,238	2,037	7,219	(5,162)	
M00-219 (M00-150) Shuntan - vs. Augmentin 875mg BID, EU (500 Pat.)	6/01	3/02	6/01	3/02	11/01	5/02	5,300	--	1,514	(1,514)	
M00-260 Shuntan Double Tap	4/01	6/02			4/01	6/03	850	--	510	(510)	
M00-216 (M99-088) AECB - Levo 500mg QD, NA	11/00	6/01	11/00	6/01	11/00	6/01	7,721	1,030	6,781	(2,881)	
M00-217 (M99-143) AECB - Azithromycin NA, EU, SAF	11/00	6/01	11/00	6/01	11/00	6/01	5,224	1,168	4,056	(2,840)	
M00-273 (M00-090) Pharyngitis - Penicillin 250 TID, N/ASA (520 pat.)	11/00	6/01	11/00	6/01	11/00	6/01	4,709	1,185	3,554	(2,199)	
M00-222 (M00-157) Pharyngitis - Penicillin 500mg QID, EU (520 pat.)	11/00	6/01	11/00	6/01	11/00	6/01	4,029	1,054	2,975	(2,321)	
								72,337	12,233	44,119	(31,218)
Other Studies											
A.D. Little Pediatric Taste Testing	3/00	2/01	3/00	2/01	3/00	2/01	270	225	45	180	
Completed Pediatric Prototype Studies	6/00	12/00	6/00	12/00	6/00	12/00	225	250	2,000	(250)	
Microbiology PK/PD Studies	1/00	12/01	1/00	12/01	1/00	12/01	3,500	1,811	--	1,689	
Pediatric PK/PD, Phase II	6/00	6/00	6/00	6/00	6/00	6/00	1,500	331	--	331	
								116,531	21,095	47,404	(74,126)

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**ANTI-INFECTIVE FRANCHISE
QUINOLONE ABT-492
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 Actual	2001 PLAN	2001 PLAN Fav/(Unfav) vs. Actual
Development	7,053	21,341	(14,278)
Milestone Payment (Phase IIA)	0	3,000	(3,000)
Total Quinolone	7,053	24,341	(17,278)
Target	6,800	25,000	(18,200)
Variance Fav/(Unf) vs. target	(253)	659	922

Key Milestones / Assumptions	'00 AGU	'01 PLAN	Status
• INITIATE PHASE I STUDIES	4Q '00	4Q '00	Complete
• INITIATE PHASE IIA SAFETY STUDY	—	3Q '01	On target
• NDA Filing	4Q '03	4Q '04	Delayed one year due to funding limitation.
PARD	'00 AGU	'01 PLAN	Fav/(Unf)
• Formulation Development	—	101	On target
• IIC Phase II	—	501	On target
• PARD Commercial	—	—	—
• Budget (PARD)	225	515	(290)
• Analytical Development & Support	274	341	(67)
• Formulation Development & Support	38	10	28
• Clinical Finishing	59	85	(36)
• Project Mgt.	—	—	—
Total	594	951	(357)

Venture Management (Total Department)

- Expense: \$12,020M (Increase of \$3,514M vs 2000 Actual; includes ABT-492 Milestone payment of \$3M)
- \$14M Milestone Payment
- Total Heads - 41, unchanged vs. AGU. Abbott full time - 33, unchanged vs. AGU.

CAPD Requirements	Kys	Heads	Pilot Plant	Personnel	Total Cost
AGU	0	0.5	480	178	598 A
2001 PLAN	600	6.0	1892	1,470	5,762 B
A) CAPD Pilot Plant 12 weeks @ \$400/week and 1 person for 6 months					
B) CAPD Pilot Plant 44 weeks @ \$43M/week, 6 headcount @ \$245M, 600kg of bulk drug.					

	1st Patient Dosed	Last CRF	ROSS 2000 AGU Start	ROSS 2000 AGU End	ROSS 2001 PLAN Start	ROSS 2001 PLAN End	Study Total	Cost (\$000) 2000 Act.	Cost (\$000) 2001 PLAN	2001 Fav/(Unfav) vs. 2000 Act
Phase I										
Single Dose/ Food Effect in Healthy Volunteers (100 pat)	11/00	01/01	4Q 2000	4Q 2000	08/01	01/01	850	680	170	510
Multiple Rising Doses in Healthy Volunteers (50 patients)	01/01	03/01	4Q 2000	4Q 2000	02/01	03/01	500	0	500	(500)
Phase I / Bio Studies (3 studies)			04/01	09/01	04/01	09/01	700		700	(700)
PHASE I TOTALS							2,050	680	1,370	(680)
Microbiology Studies							710	0	710	(710)
Phase IIA										
AECB (250 patients)	06/01	04/02			08/01	04/02	3,750	0	2,083	(2,083)
SUBTOTAL PHASE I / PHASE IIA							6,510	680	4,153	(3,483)
Phase IIB										
CAP (250 patients)	11/01	07/02			11/01	07/02	3,750	0	837	(837)
Uncomplicated UTI (300 patients)	01/02	09/02			01/02	09/02	1,650	0	0	0
Skin and Skin Structure Infection (300 patients)	01/02	12/02			01/02	12/02	2,100	0	0	0
PHASE IIB TOTAL							7,500	0	837	(837)
Total							14,010	680	5,000	(4,120)

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**ANTI-INFECTION FRANCHISE
OMNICEF
2001 PLAN KEY STATISTICS
(\$000)**

Indication	2000 AGU	2001 PLAN	2001 PLAN Fav/(Unfav) vs. AGU
Development	0	4,843	(4,843)
Total	0	4,843	(4,843)
Target	0	5,000	(5,000)
Variance Fav/(Unf) vs. target	0	157	157

Key Milestones / Assumptions	'00 AGU	'01 PLAN	Status
• INITIATE ACUTE OTITIS MEDIA STUDY		09/01	On Target

BAHD	'00 AGU	'00 AGU	Status
• To be defined			
• Budget			
• Clinical Finishing			
• Project Mgt.			
Total	0	92	(92)

Venture Management (Total Department)

- Expenses: \$12,020M (Increase of \$1,844M vs 2000 Actual); includes AIT-492 Milestone payment of \$3M.
- \$2M Milestone Payment
- Total Heads = 41, unchanged vs. AGU. Abbott T&D time = 33, unchanged vs. AGU.

CAPD Requirements		Pilot	Personnel	Total Cost
Kgs	Heads	Plant		
AGU	0	0	0	0
2001 PLAN	0	0.0	0	0

Phase	1st Patient Dosed	Last CRF	ROSS 2000 AGU		ROSS 2001 PLAN		Study Total	Cost(\$000)		2001 Fav/(Unfav.) vs. AGU
			Start	End	Start	End		2000 AGU	2001 PLAN	
Phase IV										
Acute Otitis Media 3 Arm 50 QID BID vs. Zithromax (250 mg)	08/01	07/02			08/01	05/02	6,000		3,000	(3,000)
PHASE IV TOTALS							6,000		3,000	(3,000)

Total Phase IV Totals: 6,000 AGU vs. 3,000 PLAN (3,000 Fav vs. AGU)

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**ANTI-VIRAL
KALETRA ABT-378
2001 PLAN KEY STATISTICS
(000)**

Notes	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2433	2434	2435	2436	2437	2438	2439	2440	2441	2442	2443	2444	2445	2446	2447	2448	2449	2450	2451	2452	2453	2454	2455	2456	2457	2458	2459	2460	2461	2462	2463	2464	2465	2466	2467	2468	2469	2470	2471	2472	2473	2474	2475	2476	2477	2478	2479	2480	2481	2482	2483	2484	2485	2486	2487	2488	2489	2490	2491	2492	2493	2494	2495	2496	2497	2498	2499	2500	2501	2502	2503	2504	2505	2506	2507	2508	2509	2510	2511	2512	2513	2514	2515	2516	2517	2518	2519	2520	2521	2522	2523	2524	2525	2526	2527	2528	2529	2530	2531	2532	2533	2534	2535	2536	2537	2538	2539	2540	2541	2542	2543	2544	2545	2546	2547	2548	2549	2550	2551	2552	2553	2554	2555	2556	2557	2558	2559	2560	2561	2562	2563	2564	2565	2566	2567	2568	2569	2570	2571	2572	2573	2574	2575	2576	2577	2578	2579	2580	2581	2582	2583	2584	2585	2586	2587	2588	2589	2590	2591	2592	2593	2594	2595	2596	2597	2598	2599	2600	2601	2602	2603	2604	2605	2606	2607	2608	2609	2610	2611	2612	2613	2614	2615	2616	2617	2618	2619	2620	2621	2622	2623	2624	2625	2626	2627	2628	2629	2630	2631	2632	2633	2634	2635	2636	2637	2638	2639	2640	2641
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**ONCOLOGY GROUP
ATRASENTAN (ABT-627)
2001 PLAN KEY STATISTICS
(\$000)**

Project	2001 Target	2000 AGU	2001 PLAN	PLAN vs Target Pay(Unfav) Var
Endothelin Antagonist	39,200	13,000	38,643	557

Key Milestones / Assumptions	00 AGU	01 PLAN	Status (on target, pending or delayed to x)
- Phase III Pivotal Study (M00-211)	4Q/00	5/01	Delayed to 5/01.
- Initiate Phase III Pivotal Study #2 (M00-244)	-	6/01	Delayed to 6/01.
- Qtc, Bioequivalence and Drug Interactions	-	2Q/01	On target

PARD	00 AGU	01 PLAN	Notes
- Analytics Dev & Support	601	1,555	NDA lets and ability support, plus clinical study
- Formulation Dev & Support	440	833	supply and re-supply.
- Clinical Finishing	57	1,018	
- Project Management Support	59	185	
- PARD Total	1,159	3,602	

Total Venture Management	2000 AGU	2001 PLAN	SPD Requirements	Headc	Start	End	Total	00 AGU	01 PLAN	Variance
- Expense: \$7,248M of \$11,712M			30	2	8/97	12/00	9,658			
- Authorized Heads: 38 Regular and 9 Other			2	2	1/98	12/00	3,200			
					4/01	12/01	281			(281)
					6/01	12/01	321			(321)
					1Q/02	3Q/02	0			
					1Q/02	3Q/02	0			
					4/01	8/01	162			(162)
					1Q/02	3Q/02	0			

Clinical Grants	1st Patient Dosed	Last CRF	Phase Start	2000 AGU	End	2001 PLAN	Start	End	Total	00 AGU	01 PLAN	Variance
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Phase II												
M66-584	2/98	TBD	8/97	12/99			8/97	12/00	9,658			
M67-739	4/98	TBD	1/98	12/00			1/98	12/00	3,200			
Clin Pharm	4/01	6/01	n/a	n/a			4/01	12/01	281			(281)
Clin Pharm	6/01	8/01	n/a	n/a			6/01	12/01	321			(321)
Clin Pharm	1Q/02	2Q/01	n/a	n/a			1Q/02	3Q/02	0			
Clin Pharm	1Q/02	2Q/01	n/a	n/a			1Q/02	3Q/02	0			
Clin Pharm	4/01	6/01	n/a	n/a			4/01	8/01	162			(162)
Clin Pharm	1Q/02	2Q/01	n/a	n/a			1Q/02	3Q/02	0			

Phase III												
M00-211	5/01	8/03	12/00	8/03			12/00	1/04	39,338	1,950	12,420	(10,470)
M00-244	6/01	12/04					6/01	12/04	36,000		5,888	(5,888)
M00-255	TBD	TBD					10/01	12/04	11,000		848	(848)
TBD	TBD	TBD					7/01	12/04	2,000		288	(288)

Less Clin Pharm studies									(784)		(784)	764
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Total									100,364	1,950	18,252	(17,302)
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**ONCOLOGY GROUP
TSP (ABT-510)
2001 PLAN KEY STATISTICS
(\$000)**

Project	2001		2000		2001		PLAN vs Target	
	Target	AGU	AGU	PLAN	PLAN	Fav(Unfav)	Var	
Antiangiogenesis Thrombospondin	9,000	6,600	6,600	8,981		(981)		
Milestones / Assumptions								
Initiate Phase I Multiple Dose Study		00 AGU	9/00	01 PLAN	2/01	Status (on target, pending or delayed to x)		
Pre-IND Meeting				2Q/01	On Target	Delayed - Accommodate European Ethics Committee		
Initiate IND Study				6/01	On Target			
PARF Total								
BD		00 AGU	9/00	01 PLAN	Notes			
Analytics Dev & Support			361	525				
Formulation Dev & Support			211	355				
Initial Finishing			74	165				
Project Management Support			86	105				
PARF Total			762	1,150				
El Venture Management								
Expense: \$825M of \$11,712M								
Authorized Heads: 38 Regular and 9 Other								
SPD Requirements								
					Kgs	Heads	Met'l Cost	
2000 AGU				2001 PLAN	7	5	480	
2001 PLAN							2,538	
Cost								
					Total	00 AGU	01 PLAN	
100-153					1,238	700	972	
1/A					300	225	81	
1/A					300		218	
BD					400		350	
Variance								
							(272)	
							144	
							(218)	
							(350)	
Total								
					2,238	625	1,621	
							(696)	

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

1/A

1/A

1/A

BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

1/A

1/A

1/A

BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

1/A

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1/A

BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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1/A

BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

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Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr. Fidler

IND Study

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BD

100-153

Multiple Dose in Cancer Patients

University of Texas - Dr. Fidler

University of Texas - Dr

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ABBT 0037557

Total

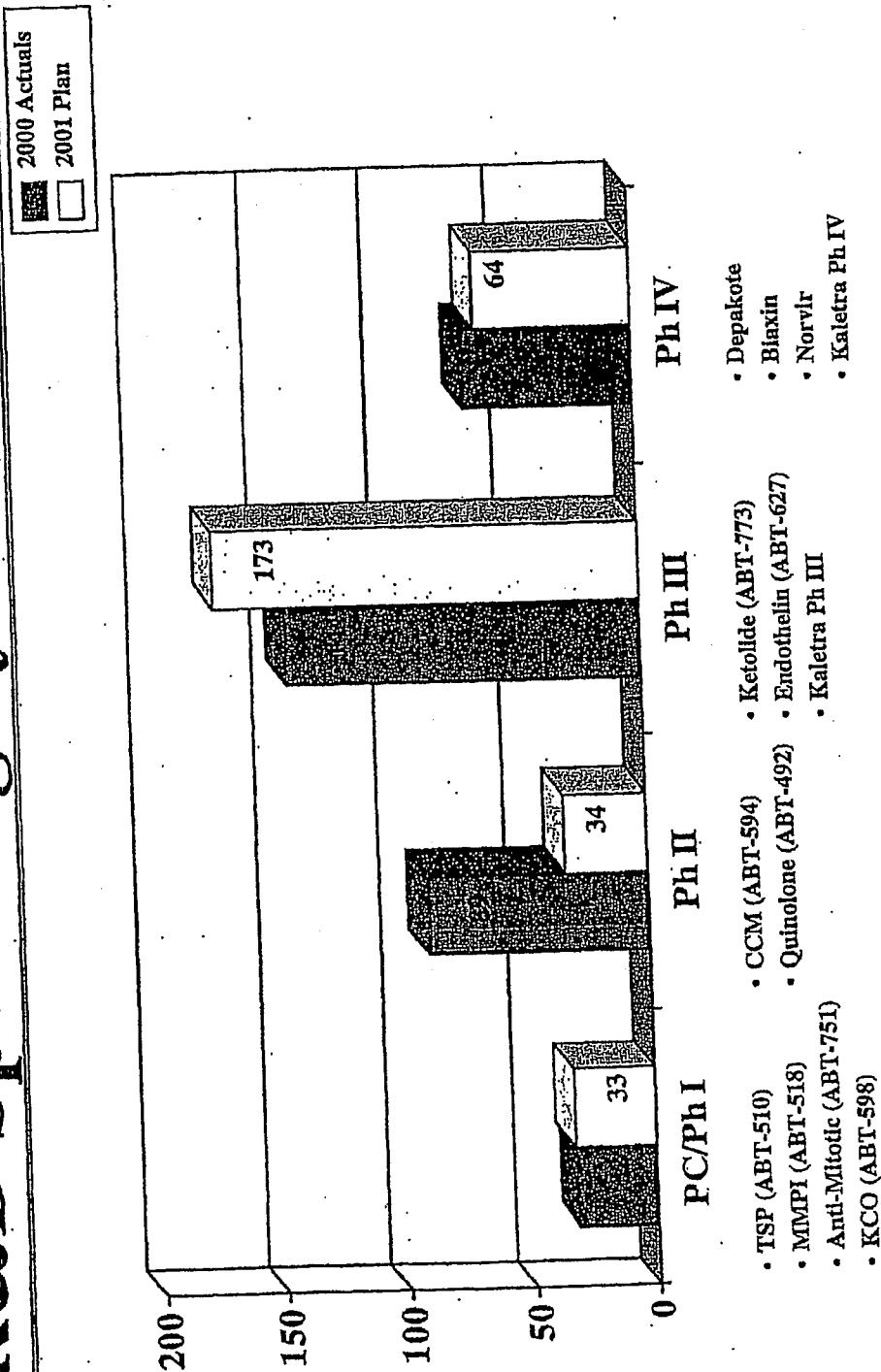
Q-Jan

ONCOLOGY GROUP
MMPI #2 (ABT-518)
2001 PLAN KEY STATISTICS
(\$000)

Project	2001		2000		2001		PLAN vs Target Fav(Unfav) Var
	Target	AGU	AGU	PLAN	PLAN		
Matrix Metalloproteinase Inhibitor	7,000	5,000	5,000	7,362		(362)	
Key Milestones / Assumptions							
		00 AGU	01 PLAN	Status (on target, pending or delayed to x)			
		10/00	1/01	Delayed - due to safety related protocol revisions			
		--	2Q/01	On Target			
		--	8/01	On Target			

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R&D Spending by Phase



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ABBT 0037560

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**Global Pharmaceutical Research & Development
Funding by Phase
2001 PLAN**

	2000 Actuals	2001 PLAN
Preclinical/Phase I		
COK-11	2.7	1.2
ABT-088 (formerly CHC9)	1.6	0.6
ASS-103	---	---
NPS-1776	7.1	---
Quinolone	2.8	---
Neuraminidase	---	5.0
KCO	7.0	10.0
TSP-41	5.6	7.4
AMPH	3.9	8.4
Anti-HIV-1	1.0	---
K-9	31.7	32.8
Subtotal PC/Phase I		
		8.3
Phase II		
ABT-584	14.3	---
Ketide	55.9	24.5
Quinolone	---	---
NS-49	1.8	---
Endothelin	18.8	33.8
Subtotal Phase II		
		88.0
Phase III		
Ketide	18.6	2.3
BPH Backup	31.5	44.2
Kalitra	80.8	---
Cyclosporine	13.6	38.9
Endothelin	---	173.3
Subtotal Phase III		
		24.1
Phase IV		
Daptone	33.6	1.4
Gabitr	---	4.0
Hydrocodone	23.4	14.8
Clarithromycin	---	4.8
Omeprazole	2.2	1.4
Flunitrazepam	10.1	4.0
Kalitra	---	6.8
Cyclosporine	68.3	2.5
Subtotal Phase IV		
		192.0
Other		
Discovery	180.6	86.1
Global Other	34.4	278.3
Subtotal Other		
		(6.8)
Affordability		

**Global Pharmaceutical Research & Development
Funding by Phase
2001 PLAN**

*Excluding Sister Divisions

Legend: (P) Phase I, (D) Phase II, (T) Phase III, (V) Phase IV

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Target Detail/ Book Pages to PPD

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2001 PLAN
Global Pharmaceutical Research & Development
R&D/Medical Expenses Summary
(\$000)

	2000 Actual	2000 AGU	2001 PLAN	2001 PLAN Fav/(Unfav) vs 2000 AGU	Memo: Global R&D
Discovery	190,618	184,750	192,000	(7,250)	192,000
Global Development	313,302	318,565	328,307	(9,742) (A)	328,307
Domestic Development	55,441	55,183	61,729	3,454	
Gross PPD	559,361	558,498	572,036	(13,538)	520,307
TAP and Sister Division	65,275	67,809	57,348	10,461	
Total Gross Expense	624,636	626,307	629,384	(3,077)	
Net PPD	375,593	374,730	385,367	(10,637)	208,124
Expense by Classification:					
Salaries/Fringe/Contract	204,133	207,042	222,483	(15,441)	
Travel/Meetings	8,452	7,800	8,327	(527)	
Other Employee Related	9,274	8,999	9,901	(902)	
MIS	5,074	5,074	5,074	...	
Corp Allocation	21,869	21,894	22,924	(1,030)	
Other	375,834	379,140	370,439	8,701 (A)	
Affordability	...	(3,642)	(9,764)	6,122	
Total Expense	624,636	626,307	629,384	(3,077)	

Commentary:

(A) Primarily due to increased support for Quinolone, Ketolide and Endothelin.

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2001 PLAN (FINAL)
 PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
 GLOBAL/COMBUSTIBLE B/LIT
 (Sheet)

Actuals through 2000 GROSS	2000 AGU GROSS	2001 PLAN GROSS	2001 PLAN PDD	PLAN vs AGU FAV/UNF	
				GROSS	PDD
FRANCHISES					
NEUROLOGY					
Depakote	30.4	30.4	24.1	6.3	6.3
Gabapin	3.0	1.4	1.3	0.8	0.5
ABT-554 (formerly CCM)	14.4	8.8	5.6	5.1	3.0 (A)
CCM-II	4.0	2.2	0.7	2.8	1.7
ABT-088 (formerly CHCM)	3.0	0.6	0.4	2.4	1.4
ASB-103	---	---	---	---	---
ASB-103	---	---	---	---	---
NP-1778	---	4.0	4.0	---	---
NP-Schwarz /Ataz (Hydrocodone)	---	40.8	38.1	---	---
Subtotal NEUROLOGY	83.8	48.0	38.1	13.2	6.8
ANTI-INFECTIVE					
Clindamycin	28.4	14.9	8.8	11.5	6.8
Keloides	74.1	44.5	52.8	13.9	(8.3) (C)
Keloides Task	(7.0)	---	---	(7.0)	(4.2)
Quinolone	6.8	4.1	1.7	---	---
Quinolone	2.5	1.5	1.7	2.5	1.5
Neuraminidase	---	---	---	---	---
Ombid	102.8	4.9	4.9	4.9	(4.9)
Subtotal ANTI INFECTIVE	61.1	132.1	81.3	28.4	(18.6)
UROLOGY/CARDIOLOGY					
BPH Backup	54.0	2.3	1.4	31.7	18.0 (B)
Fenofibrate (Fountain)	1.0	1.4	1.4	0.4	(0.4)
Nippon Shinyaku (NS49)	2.7	---	---	2.7	2.2
KCO	31.7	5.0	4.0	6.0	4.0
Subtotal UROLOGY/CARDIOLOGY	23.6	8.7	8.8	38.0	16.0
HIV					
Ritonavir	13.0	4.0	2.4	8.0	5.4
Kaletra	78.5	51.0	30.6	25.5	18.1 (E)
Zalcitabine	7.5	2.5	1.5	9.2	8.9
Subtotal HIV	61.3	57.5	34.5	43.7	28.4
CANCER					
Endoxan	13.0	38.8	23.3	25.8	(15.5) (C)
TSP #1	8.8	10.0	8.0	3.4	(2.0)
Melphalan	5.0	7.4	4.4	2.4	(1.4)
Melphalan	6.0	8.4	5.0	2.4	(0.2)
Anti-Keloid	1.0	0.8	---	1.0	0.8
K-3	---	---	---	---	---
FTI #2	31.8	84.8	38.7	33.0	(18.5)
Subtotal CANCER	20.2	86.1	38.7	33.0	(18.5)
Other New Products					
Other	60.2	86.1	78.7	35.9	(28.2)
Amendability	(3.6)	(8.8)	(5.9)	8.2	3.7
Total Development	373.6	380.0	270.3	18.3	(6.4)
Discovery	184.8	182.0	115.2	7.3	(4.3)
Total Gross/Net PPD	588.8	572.0	305.4	113.8	(19.1)

Comments:
 (A) Funding assumes No Go decision at 2001 decision point
 (B) BPH Backup project was killed 1000 and reflects shut down expenses in 2001
 (C) Reflects higher costs associated with Phase II
 (D) Reflects higher costs associated with Phase II
 (E) Decrease reflects year 2000 launch

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**PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT
GLOBAL A1 SPLIT
(MILLIONS)**

	2005 PLAN		2006 PLAN		2007 PLAN	
	Global	Domestic	Global	Domestic	Global	Domestic
NEUROLOGY						
Depakote	24.7	—	24.7	—	—	24.1
Gabapentin	1.5	—	1.5	—	—	1.4
ABT-594 (formerly CCN)	13.0	—	13.0	—	—	—
Co-D	—	—	—	—	—	1.3
ABT-499 (formerly CHCH)	—	—	—	—	—	0.8
ABT-103	—	—	—	—	—	—
ABT-176	—	—	—	—	—	—
RP Salmer / Alac (Hydrocodone)	—	—	—	—	—	4.0
ANTI-INFECTION	12.3	—	12.3	—	11.1	29.3
Cefixime	22.0	—	—	—	—	—
Reslizade	71.3	—	—	—	—	14.9
Quinolone	14.0	—	—	—	—	40.0
Neuroleptics	5.4	—	—	—	—	24.5
Omniol	—	—	—	—	—	—
UROLOGY/CARDIOLOGY	11.1	—	—	—	12.4	4.9
BRIL-1	31.0	—	—	—	2.3	—
Tiludronate	—	—	—	—	—	1.4
Nigam Shikayon (NS-40)	5.4	—	—	—	—	—
PCO	—	—	—	—	—	—
HTV	41.3	—	—	—	—	1.4
Ruvacivir	13.0	—	—	—	—	—
Kalena	24.6	—	—	—	—	—
Cytosine	7.7	—	—	—	—	—
CANCER	93.3	—	—	—	57.3	—
Endothelin	4.0	—	—	—	—	—
Metoprolol (MOP)	5.0	—	—	—	—	—
Fenpropionylamine (FTI) #2	3.8	—	—	—	—	—
TSP #1	5.0	—	—	—	—	—
TSP #2	1.0	—	—	—	—	—
Anti-Mitotic	5.9	—	—	—	—	—
K5	—	—	—	—	—	—
Other New Products	32.8	—	—	—	64.6	—
Other	7.2	—	—	—	—	—
Other	25.6	—	—	—	64.6	17.2
Total Development	357.8	—	—	—	316.8	63.0
Discovery	151.0	—	—	—	193.0	—
Total PPD (Without R&D)	541.8	—	—	—	518.8	63.0
Risk/Repeatability	(45.7)	—	—	—	(4.3)	(1.3)
Total PPD (With R&D)	497.1	—	—	—	514.5	61.7

GLOBAL A1 SPLIT						
At Split at Clinical @ 40%	198.8	—	—	—	208.1	—
At Split per IDV	183.8	—	—	—	186.7	—
Unsplit (Over) Charge	15.0	—	—	—	21.4	—

Note: A1 Split from 40% A1 split results in IDV reduced
 License fees from 40% A1 split to 40% A1 split

Book II IDV was \$198,870
 Per Jeff McGinnis A1 split was \$12,000 less
 \$198,870 - \$12,000 = \$186,870
 \$186,870 - \$12,000 A1 Undercharge

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PHARMACEUTICAL PRODUCTS RESEARCH & DEVELOPMENT

	Corporate Submission	Final 2004 PLAN	Final vs. Corp Sub Inc/(Dec)
NEUROSCIENCE			
Depakote	28.0	24.1	(1.9)
Gabapril		1.4	1.4
ABT-694	8.8	8.3	0.4
COX - II	3.0	1.2	(1.8)
ABT-989	7.0	0.6	(6.4)
ABT-103	3.3		(3.3)
NPS-1778	3.7		(3.7)
RP Scherer / Alza	4.0	4.0	
Subtotal NEUROLOGY	65.8	40.6	(16.3)
ANTI-INFECTIVE			
Clarithromycin	20.0	14.9	(5.1)
Ketolide	81.0	86.0	(3.0)
Quinolone	25.0	24.5	(0.5)
Neuraminidase			
Ornithel	6.0	4.9	(1.1)
Subtotal ANTI-INFECTIVE	141.0	132.3	(8.7)
UROLOGY/CARDIOLOGY			
BPH Backup	25.4	2.3	(23.1)
Fenofibrate (Fournier)	4.0	1.4	(2.6)
Nippon Shinyaku (NS48)			
KCO	6.0	6.0	(1.0)
Subtotal UROLOGY/CARDIOLOGY	35.4	9.7	(25.7)
HIV			
Ritonavir	4.0	4.0	
Kaletra	41.5	51.0	9.5
Cyclosporine	2.0	2.5	0.5
Subtotal HIV	47.5	57.5	10.0
CANCER			
Endothelin	23.0	38.8	15.8
TSP #1	9.0	10.0	1.0
Metalloproteinase	7.0	7.4	0.4
Anti-Mitotic	10.0	8.4	(1.6)
K-6	8.8		(8.8)
FTI #2	4.1		(4.1)
Subtotal CANCER	61.9	64.6	2.7
Other New Products			
Other	78.5	86.1	7.6
Affordability	(25.1)	(9.8)	15.3
Total Development	385.1	380.0	(5.1)
Discovery	197.0	192.0	(5.0)
Total Gross PPD	582.1	572.0	(10.1)
TAP & Sister Division	59.2	57.4	(1.8)
Total Gross	641.3	629.4	(11.9)

Lundbeck Pharmaceuticals, Inc. is a U.S. subsidiary of Lundbeck A/S, Denmark.

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Pre-Announced
Pharmaceutical Research & Development
Expense Breakdown
2001 PLAN

XX Given to McKersy
CONSULTING ON 2/12/2001 XX

Needs to Be
Reviewed By Management

FRANCHISES	Strategic/ Mandatory R&D Program	Grants	SPD Direct Costs	Other Fixed Costs*	Other Variable Costs**	2001 PLAN Target	Potential Expense Savings**	Strategic/ Mandatory R&D Expense	Total Expense Savings
NEUROLOGY									
Dipakate	Yes	6.4	--	7.5	7.4	24.1	16.7	(16.7)	--
Gabril	Yes	1.1	--	0.7	0.7	1.4	0.7	(0.7)	--
ABT-584 (formerly CCM)	Yes	1.3	--	4.1	4.1	9.3	2.2	(2.2)	--
COX- II	Yes	0.1	--	0.5	0.6	1.2	0.6	(0.6)	--
ABT-988 (formerly CHCM)	Yes	--	--	0.3	0.3	0.6	0.3	(0.3)	--
ABS-103	No	--	--	--	--	--	--	--	--
NPS-1778	No	--	--	--	--	--	--	--	--
PP Scherer / Abza (Hydrocodone)	Yes	10.6	--	2.0	2.0	4.0	2.0	(2.0)	--
Subtotal NEUROLOGY				14.8	16.1	40.6	26.6	(26.6)	--
ANTI-INFECTION									
Chloritromycin	Yes	2.9	4.0	4.0	4.0	14.9	10.9	(10.9)	--
Ketolide	No	47.4	9.4	16.8	16.8	89.0	72.4	--	72.4
Quinolone	Yes	5.0	2.4	8.6	8.6	24.5	15.9	(15.9)	--
Neuraminidase	No	--	--	--	--	--	--	--	--
Omicef	No	3.0	--	0.5	1.0	4.5	3.9	--	3.9
Subtotal ANTI-INFECTION		58.3	16.8	29.0	29.2	132.3	103.1	(26.8)	78.3
UROLOGY/CARDIOLOGY									
BPH Backup	Yes	--	--	1.1	1.2	2.3	1.1	(1.1)	--
Fenofibrate (Fournier)	Yes	--	--	0.7	0.7	1.4	0.7	(0.7)	--
Nippon Shinyaku (NS48)	No	--	--	--	--	--	--	--	--
KCO	No	0.4	--	2.3	2.3	5.0	2.7	--	2.7
Subtotal UROLOGY/CARDIOLOGY		0.4	--	4.1	4.2	8.7	4.5	(1.8)	2.7
HIV									
Rilamvir	Yes	1.2	--	1.4	1.4	4.0	2.6	(2.6)	--
Kaletra	Yes	22.6	--	14.2	14.2	61.0	36.8	(36.8)	--
Cyclospine	Yes	1.0	--	0.7	0.8	2.5	1.7	(1.7)	--
Subtotal HIV		24.8	--	16.3	16.4	67.5	41.1	(41.1)	--
CANCER									
Endoxifen	Yes	18.3	0.2	8.8	9.7	36.8	28.1	(28.1)	--
TSP #1	No	1.6	--	4.2	4.2	10.0	6.8	--	6.8
Relatoproteinase	No	1.1	--	3.1	3.2	7.4	4.2	--	4.2
Anti-Mitotic	No	1.1	0.3	3.5	3.5	8.4	4.8	--	4.8
K-5	No	--	--	--	--	--	--	--	--
FTI #2	No	--	--	--	--	--	--	--	--
Subtotal CANCER		22.1	0.5	20.4	20.8	64.6	44.0	(29.1)	14.9
Other New Products	No	--	--	--	--	--	--	--	--
Other	Yes	0.6	0.6	42.3	42.4	86.1	43.7	(43.7)	--
Affordability	Yes	--	--	(4.9)	(4.9)	(9.8)	(4.9)	4.9	--
Total Development		118.0	16.6	122.1	123.0	380.0	257.0	(163.1)	83.9
Discovery	Yes	--	0.4	85.8	85.8	162.0	88.2	(88.2)	--
Total Gross PPD		118.0	17.0	217.9	218.8	572.0	345.2	(268.3)	83.9

* Calculated using the rationale that 80% of remaining costs could be cut via headcount reductions, PPD material reductions, lab supplies, etc.
** Includes all costs that are considered variable (Grants, SPD Direct Costs, and Other Variable Costs).

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Pharmaceutical Products Division - R&D
Summary of R&D Projects
2001 PLAN

Project/Description	Cost thru 2000	2000 Actual	2001 PLAN	Cost until NDA 2001 and Forward
Depakote Development program to enhance the Depacon/Depacon product position in the treatment of migraine headaches and the treatment of manic episodes associated with bipolar disorder. This includes a new extended release formulation in each of these treatment areas and studies to expand the market for treating impulsive aggression, psychosis, elderly agitation, a comparator study with Lilly's anti-psychotic drug, Zyprexa, and bipolar in pediatric mania. Additionally, the Depacon Rapid Infusion Study will assess the safety of rapidly loading Depacon in patients with Epilepsy. Two new formulations are being developed - 250 mg ER tablet and DR Spinning Disk.	\$179.9	\$33.6	\$24.1	N/A
ABT-594 [Milestone: Go/No Go Clinical Efficacy, 2Q01, NDA Dates 2Q03] ABT-594 is a non-opioid, non-NMDA antagonist that is a potent and selective neuronal nicotinic receptor modulator. It is effective across all pain conditions: nociceptive pain and neuropathic pain. Preclinical data shows ABT-594 to be 30 to 100 times more potent and equally efficacious to morphine in several well characterized animal models of nociceptive pain. ABT-594 has a unique mechanism of action which may encourage use in combination with other analgesics as well as monotherapy. Indicated for the management of neuropathic pain associated with diabetic polyneuropathy. Indication or publication for specific chronic nociceptive and/or neuropathic pain condition (e.g. OA). Oral formulation expected. Dosing schedule to be determined.	\$62.2	\$14.3	\$9.3	\$71.0
ABT-089 [Milestone: Transition Team Go/No Go, 4Q01] ABT-089 is a potent and selective neuronal nicotinic receptor modulator with cognition enhancing activity in rodent and primate preclinical models of cognitive dysfunction. It does not appear to have nicotine like dependence liability or abuse. ABT-089 may be the second non-scheduled, non-stimulant product for the ADHD market. Oral formulation and QD dosing expected.	\$1.6	\$1.6	\$0.6	\$102.3
Clarithromycin The sNDA for clarithromycin extended release (Biaxin XL) was approved March 3, 2000. New studies planned for the U.S. include Asthma and Cystic Fibrosis. International Projects for 2001 include OD XL registration studies and the Japan 400mg tablet.	\$393.8	\$23.3	\$14.9	N/A
Ketolide (ABT-773) [Milestone: Phase III CAP/AMS dose range data 2Q01, Tablet NDA 3Q02] ABT-773 is a potent ketolide with strong activity against most susceptible resistant strains while also maintaining the broad spectrum coverage of clarithromycin. Product will be available as tablet followed by a pediatric suspension and injectable form dependent on timing of funding. ABT-773 will address the major unmet medical needs of increasing resistance to current cephalosporins and weak activity against key problem pathogens, especially S. pneumoniae. Maximum efficacy claim of "Specimen the specimen" (G+, G-, mycoplasma). Cover key G+ resistant strains (S. pneumoniae, S. pyogenes). Tablets dosing will be QD or BID based on severity of indication. Five days for ABECB, Pharyngitis, 10 days for AMS and CAP. CQDS no more than \$2,500/kg at launch. Pediatrics and IV currently not funded.	\$133.8 (Tab)	\$74.5 (Tab)	\$88.0 (Tab)	\$42.0 (Tab US/EU)
Quinolone (ABT-492) [Milestone: Go/No Go PK/Safety (Phase Ia) 2Q01, NDA Dates 4Q04] ABT-492 is a broad-spectrum anti-infective agent with potential application across a range of indications, including respiratory infections, gastrointestinal infections, and skin/soft tissue infections. Product will initially be available as tablet/capsule followed by an injectable form approximately one year later. The in vitro antibacterial activity of ABT-492 appears to be more potent than levofloxacin. The in vivo potency data suggested that ABT-492 has the potential to be therapeutically effective at doses comparable to levofloxacin. Must have a safety profile comparable to levofloxacin. QD dosing for adult tablets/capsule and IV. Five days for most indications.	\$11.6	\$7.1	\$24.5	\$227.6 (Tab)
Omnicef [Milestone: Initiate Clinical Studies Q301, sNDA Q402] Cefdinir (Omnicef) is a potent cephalosporin indicated for the full range of respiratory tract and skin infections, and has 5 day BID indication for AOM, pharyngitis, and ABECB. The suspension is pleasant tasting, significantly better than Cefadil and Augmentin in 2 studies, and better than Zithromax in 1 of 2 studies. A new study will pursue claims for 5 day, once daily dosing in AOM, and generate comparative data vs. Zithromax with both once daily and twice daily dosings. A second study is planned for ABECB and is currently Blue Plan. Companion agents are under evaluation. The sNDA would be filed Dec 2002.	\$0.0	\$0.0	\$4.9	N/A
Benign Prostatic Hyperplasia Back-up (ABT-980) [Program terminated 1Q00] ABT-980 is a potent @ selective androgen receptor antagonist with 100-fold selectivity for @16 versus @16 receptor in the medical treatment of benign prostatic hyperplasia. Indicated for the relief of symptomatic benign prostatic hyperplasia. ABT-980 program had to be terminated in 1Q00 due to the development of serum prostate-specific antigenemia in patients.	\$85.7	\$31.5	\$2.3	\$0.0

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**Pharmaceutical Products Division - R&D
Summary of R&D Projects
2001 PLAN**

Project/Description	Cost thru 2000	2000 Actual	2001 PLAN	Cost until NDA 2001 and forward
Kaletra ABT-378 is a second generation protease inhibitor which will be reformulated in one capsule/tablet with ritonavir. It is a potent against HIV protease with a Ki of 100 pM. Phase I studies indicate that ABT-378 is safe and well tolerated at all doses studied. ABT-378 works only in combination with ritonavir. Ritonavir acts as a potent booster of the PK profile of ABT-378 to achieve higher blood levels than on its own. Indicated as first-line protease inhibitor therapy in adults. Efficacy against resistant virus. Maintain high plasma and tissue concentrations. Safety, side effect, and toxicity profile at least equal to current standard. Dosing: BID, QD possible. Will be available in one coformulated pill with ritonavir.	\$215.7	\$80.8	\$51.0	N/A
Endothelin (ABT-627) ABT-627 is a human's leading endothelin antagonist receptor. ABT-627 is seeking an indication for the treatment of hormone refractory prostate cancer. ABT-627 is orally administered and well tolerated as chronic therapy. It has demonstrated improvement of time to disease progression compared to placebo. It has also demonstrated improvement in time to PSA progression compared to placebo.	\$96.4	\$16.8	\$38.8	\$51.0
TSP H1 (ABT-510) ABT-510 is a novel thymopentin mimetic. TSP is an angiogenesis inhibitor that may prevent growth of primary tumors as well as prevent the spread of metastases by inhibiting the growth of. Solitarily vessels required to provide blood to growing tumors. With a relatively benign toxicity profile, this class of agents may be used to prevent metastatic disease in patients who have received surgery, radiation or chemos as primary therapy to treat cancer patients. An chronic, long-term therapy, there is potential for significant commercial opportunity.	\$11.0	\$7.0	\$10.0	\$80.5
Metalloproteinase (MMPI) (ABT-518) ABT-518 is an oral, matrix metalloproteinase inhibitor and a cytotoxic agent. MMPIs may prevent the growth of metastatic disease and inhibit primary tumor growth. These agents will most likely be used with current therapy or post-definitive therapy such as surgery, radiation and chemotherapy. As chronic, long-term therapy, there is significant commercial upside.	\$5.6	\$3.6	\$7.4	\$86.3
Anti-Mitotic (Eltax) (ABT-751) ABT-751 is an oral cytotoxic agent that inhibits tumor growth by inhibiting the polymerization of tubulin into microtubules, a necessary step in cell division. This mechanism of action is somewhat similar to the mechanism of taxanes. This novel agent could produce clinical benefits equal to or superior to current taxanes and could be as commercially successful as current taxanes. ABT-751 also has the potential to be effective in patients experiencing resistance to other agents, including taxanes.	\$3.9	\$3.9	\$8.4	\$78.0
Other Other projects include Gabirin, COX-II, ABS-103, NPS-1776, Hydrocodone, Fendibnax, KCO, Ritonavir, Cyclosporine, CAPD Excess Capacity Charges, and CAPD Civil process improvements.	N/A	\$68.6	\$105.6	N/A
Affordability Reflect Risk.	N/A	\$0.0	(\$9.8)	N/A
Discovery Funding provided for five Discovery Development Candidates (DDCs) to be brought forth in 2001. Reflects Discovery costs in Infectious Disease Research, Metabolic Disease Research, Neurological and Urological Disease Research, and Cancer Research. Includes Neutrasearch, Koro Bio, ICAgen, IDUN, Inpreye and ISIS collaborations.	N/A	\$190.6	\$192.0	N/A
Total Gross PPD	N/A	\$559.4	\$572.0	N/A

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**Pharmaceutical Products Division RAD
Part Ongoing Follow-on
Cost Expense**

	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL
Reductions													
Other Functional Expenses	(2,524)	(1,820)	(2,620)	(2,448)	(1,444)	(2,114)	(2,624)	(2,178)	(2,103)	(2,394)	(2,532)	(2,451)	(24,490)
RPH Grants	(107)	(100)	(102)	(102)	(100)	(102)	(102)	(102)	(102)	(102)	(102)	(102)	(1,119)
CCM Grants	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(2,953)
Other Grants	0	0	0	0	0	0	0	0	0	0	0	0	0
AI Costs	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(1,285)
Total Reductions	(2,985)	(2,274)	(3,076)	(2,804)	(1,794)	(2,460)	(2,978)	(2,387)	(2,312)	(2,648)	(2,986)	(2,857)	(28,727)
Additions													
Other	342	342	342	342	342	342	342	342	342	342	342	342	4,104
RPO Purchases	378	378	378	378	378	378	378	378	378	378	378	378	4,553
Total Additions	720	720	720	720	720	720	720	720	720	720	720	720	8,657
Change in Net Affordability (RPA to RPA)	435	446	417	417	417	417	417	417	417	417	417	417	5,481
Adjustment	2,550	2,128	2,659	2,387	1,377	2,043	2,561	2,070	2,025	2,231	2,569	2,440	(24,246)
Reductions													
Other Functional Expenses	(2,543)	(1,813)	(2,613)	(2,443)	(1,443)	(2,113)	(2,623)	(2,173)	(2,103)	(2,393)	(2,533)	(2,453)	(24,483)
RPH Grants	(107)	(100)	(102)	(102)	(100)	(102)	(102)	(102)	(102)	(102)	(102)	(102)	(1,119)
CCM Grants	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(247)	(2,953)
Other Grants	0	0	0	0	0	0	0	0	0	0	0	0	0
AI Costs	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(1,285)
Total Reductions	(2,957)	(2,260)	(3,061)	(2,796)	(1,797)	(2,461)	(2,973)	(2,387)	(2,312)	(2,642)	(2,982)	(2,859)	(28,717)
Additions													
Other	342	342	342	342	342	342	342	342	342	342	342	342	4,104
RPO Purchases	378	378	378	378	378	378	378	378	378	378	378	378	4,553
Total Additions	720	720	720	720	720	720	720	720	720	720	720	720	8,657
Change in Net Affordability (RPA to RPA)	463	460	459	464	463	463	463	463	463	463	463	463	5,440
Adjustment	2,487	2,168	2,680	2,383	1,380	2,037	2,555	2,067	2,037	2,227	2,567	2,477	(24,277)

Summary of Funding

Fund Plan	100.000
% Revenue 2005 AGU	0.00%
Bank 87	100.000
% Revenue 2006 AGU	0.00%
Bank 91	100.000
% Revenue 2007 AGU	0.00%
2008 AGU	100.000

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Other Miscellaneous Schedules

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2001 Project Funding by Phase

Franchise	Pre-Clinical	(\$MM)	Phase I	(\$MM)	Phase II	(\$MM)	Phase III	(\$MM)	Phase IV	(\$MM)	2000 AGU
Neuroscience	COX-II COX-II ABS-103 NPS-1778 ABS-103	1.6 1.2 1.3 3.7 4.0	ABT-089 ABT-089	6.4 0.6	COX Neuro COX Neuro COX Osteo	16.0 10.1	Hydrocortone	4.0	Depakote Original Depakote New Incremental Depakote Gablid	24.1 2.0 8.0 1.4	53.8
Anti-Infective			Quinu: Tablet Quinu: Tablet	24.5 0.5	Keto: Tablet Keto: Japan Reg Keto: IV Form	88.0 3.0 7.0	Omni: Chills Meds Omni: AECB Omni: Pharyngitis	2.4 2.5 5.0	Clart: TBD Clart: Cyclic Fibrosis Clart: Asthma Incremental Clart Clart: Intestinal Fenoc: Diabetes Fenoc: Diabetes	14.9 0.7 2.4 6.0 2.0 1.4 2.8	102.8
Urology/Cardiology	KCO	5.0					Bimodal BPH Backup	11.7 2.5			37.7
HIV/Immunosclerosis	Gengrat: PREFER Gengrat: Peds PK	1.0 1.0					Fluoxetine Combo 2nd Gen: HIV, BID, Oral 2nd Gen: Imp Form 2nd Gen: Oral Appl Gengrat: Organ Reg Q 2nd Gen: CD Program	4.0 12.0 4.0 2.0 2.5 17.0	2nd Gen: PIV Sustiva 2nd Gen: PIV Switch Other 2nd Gen	2.0 3.0 8.0	101.2
Oncology	MMP KS FTI	7.4 6.8 4.1	TSP-1 Anti-Mitotic	10.0 8.4			Endo: Prostate CA Endo: Breast Ca	37.8 1.0			31.6
Other	DDC-1 DDC-2 Discovery DDC-3 DDC-4 DDC-5 DDC-6	5.0 5.0 192.0 5.0 5.0 5.0 5.0	Other In-licensed**	86.1 30.0			Endo: Early Pcs Endo: Early Pcs Endo: Early Pcs	11.0 5.0			235.0
2001 Allotability		(6.8)									
2001 Total Funded		205.8		129.8		97.3		84.5		19.8	
2001 Total Unfunded		55.7		38.9		38.1		48.7		572.0	
2000 Allotability		(3.6)								201.1	
2000 AGU		201.4		72.0		124.1		77.0		598.5	

Rev:	Funded	Unfunded
Green:		
Red:		

* All fixed costs in "other" arbitrarily placed in phase 1.
 ** In-licensed compounds may vary in both franchise and phase.

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Pharmaceutical Products Research & Development
R&D/Medical Expenses Summary
(\$000)

	1998 ACTUAL	1999 ACTUAL	2000 PLAN	2000 APU	2000 AGU	2001 PLAN
Global Discovery	162,565	170,792	185,000	185,000	184,750	192,000
Global Development	263,041	248,486	312,126	327,300	318,565	328,307
Subtotal Global	425,606	419,278	497,126	512,300	503,315	520,307
% growth vs. prior year		-5.5%	25.6%	4.9%	-2.7%	3.1%
A.I. \$ share	170,242	165,911	183,768	183,768	183,768	186,670
A.I. % share	40.0%	39.6%	37.0%	35.9%	36.5%	35.9%
A.I. % share growth		-2.5%	10.8%			1.6%
PPD \$ share	255,364	253,367	313,358	328,532	319,547	333,637
PPD % share	60.0%	60.4%	63.0%	64.1%	63.5%	64.1%
PPD % share growth		-0.8%	23.7%			6.5%
Domestic Development	66,861	63,876	56,290	55,183	55,183	51,729
Gross PPD	492,467	483,154	553,416	567,483	558,488	572,036
TAP and Sister Division	58,700	58,301	52,694	65,459	67,809	57,348
Total Gross Expense	551,167	541,455	606,110	632,942	626,307	629,384
Net PPD	322,225	315,443	369,648	383,615	374,730	385,367

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Detail of "Other"
2001 PLAN

	Oracle			Adjustments			2001 PLAN			2000 ACU			Variance Favyl/Unfav
	Global	Domestic	Total	Global	Domestic	Total	Global	Domestic	Total	Global	Domestic	Total	
Non-Promoted Products													
Altemer Degrade	110	--	110	--	--	--	119	--	119	2,009	--	2,009	1,493
In Use/ongoing	403	--	403	--	--	--	403	--	403	1,701	--	1,701	1,353
Expendable/Other	408	--	408	--	--	--	408	--	408	925	--	925	457
Perforation for Growth	123	--	123	--	--	--	123	--	123	927	--	927	804
Simulated	71	--	71	--	--	--	71	--	71	--	--	--	(71)
NS-40 AST-322	57	--	57	--	--	--	57	--	57	--	--	--	(57)
Abolition & Retirement Pre-LX	--	38	38	--	--	--	--	38	38	--	--	--	(38)
Molecular Probe	--	--	--	1,207	1,207	2,414	--	--	--	--	1,851	1,851	744
Drug User Fees	--	--	--	--	--	--	--	--	--	--	200	200	200
Private to Operations	--	--	--	3,168	3,168	6,336	--	--	--	2,289	--	2,289	(607)
Dept & Floorpace not in hand	--	--	--	--	--	--	--	--	--	(5,749)	--	(5,749)	(5,749)
Inventory Transfer AST 378	--	--	--	200	200	400	--	--	--	200	--	200	--
Global Supplies (Operations)	--	--	--	--	--	--	--	--	--	2,440	--	2,440	2,440
Services	--	--	--	--	--	--	--	--	--	1,500	--	1,500	1,500
SDG/Other	--	--	--	--	--	--	--	--	--	--	--	--	--
IT Productivity Projects	--	--	--	--	--	--	--	--	--	1,000	--	1,000	1,000
Koch/INNOVOCOR	--	--	--	--	--	--	--	--	--	500	--	500	500
Genentix	--	--	--	--	--	--	--	--	--	--	--	--	--
Genentix 02	--	--	--	--	--	--	--	--	--	--	--	--	--
Coastline	--	--	--	--	--	--	--	--	--	171	--	171	171
CI charge from Ops (On Val Mgr)	--	--	--	--	--	--	--	--	--	807	--	807	807
SPD EN - Unmanned	--	--	--	--	--	--	--	--	--	852	--	852	852
Apple Insurance	--	--	--	--	--	--	--	--	--	1,078	--	1,078	1,078
Data Management Absorption	--	--	--	--	--	--	--	--	--	2,850	--	2,850	2,850
Other New Products	--	--	--	--	--	--	--	--	--	144	--	144	144
All Mergers	--	--	--	--	--	--	--	--	--	--	--	--	--
	1,222	34	1,256	3,273	1,207	4,480	4,905	1,243	6,148	13,412	2,151	15,563	9,713
Non-Promoted Products													
Chel	--	2,480	2,480	--	--	--	--	2,480	2,480	--	2,480	2,480	--
WAC	--	2,564	2,564	--	--	--	--	2,564	2,564	--	2,564	2,564	--
New Candidates	83	1,973	2,056	--	--	--	83	8,073	8,156	1,582	10,991	12,573	4,417
All Other (Total Below)	83	13,121	13,204	--	--	--	83	13,121	13,204	1,582	14,028	15,610	2,407
SPD Misc													
Outsourcing	--	--	--	--	--	--	--	--	--	652	--	652	652
Purchasing Allow/Other	--	--	--	--	--	--	--	--	--	--	--	--	--
Viscous Lab	--	--	--	--	--	--	--	--	--	652	--	652	652
SPD Process													
Unit of Activity Charge	23	--	23	--	--	--	23	--	23	28	--	28	8
City & Air Charge Improve	--	357	357	--	--	--	--	359	359	638	--	638	270
Cell Process Improve	1,973	--	1,973	--	--	--	1,973	--	1,973	2,507	--	2,507	834
IQG	7,152	--	7,152	--	--	--	7,152	--	7,152	--	--	--	(7,152)
New Project Support	--	--	--	--	--	--	--	--	--	--	--	--	--
Doc - Delivery	--	--	--	--	--	--	--	--	--	--	--	--	--
Discovery Initiate & Track/execute	370	--	370	--	--	--	370	--	370	--	--	--	(370)
Flood Cost to SPD (PARO)	--	--	--	--	--	--	--	--	--	--	--	--	--
Process 2nd Gen (Mfg Chg)	--	--	--	--	--	--	--	--	--	--	--	--	--
Cell N	4,297	--	4,297	--	--	--	4,297	--	4,297	4,700	--	4,700	403
ROD - Head MCPP	--	--	--	--	--	--	--	--	--	5,728	--	5,728	5,728
Amalgamite - Flood MCPP	--	--	--	--	--	--	--	--	--	4,700	--	4,700	403
Microbubbles Adjustment	--	--	--	--	--	--	--	--	--	151	--	151	151
	13,915	359	14,144	--	--	--	13,915	359	14,144	13,112	639	13,751	(403)
Excess Capacity - SPD													
PPD RAD Key Control	11,010	--	11,010	--	--	--	11,010	--	11,010	9,160	--	9,160	(2,450)
PPD RAD Suspense	--	--	--	--	--	--	--	--	--	--	--	--	--
Corp Key Control	--	--	--	--	--	--	--	--	--	--	--	--	--
Mfg Suspense	11,010	--	11,010	--	--	--	11,010	--	11,010	9,160	--	9,160	(2,450)
Excess Capacity - PPD													
Discovery	--	--	--	--	--	--	--	--	--	357	--	357	357
Drug Safety	--	--	--	--	--	--	--	--	--	834	--	834	834
Development Ops	--	--	--	--	--	--	--	--	--	35	--	35	35
Venue Management (Theatrical)	--	--	--	--	--	--	--	--	--	--	--	--	--
Venue Mgmt	--	--	--	--	--	--	--	--	--	1,162	--	1,162	1,162
PARO	--	--	--	--	--	--	--	--	--	89	--	89	89
Data Management (Data over/under)	--	--	--	--	--	--	--	--	--	2,000	--	2,000	2,000
	--	--	--	--	--	--	--	--	--	3,201	1,240	4,441	4,441
Other Miscellaneous Credits													
DRO Rebates	--	--	--	(3,000)	--	(3,000)	--	--	--	--	--	--	3,000
New Initiatives	--	--	--	--	--	--	--	--	--	(1,500)	--	(1,500)	(1,500)
FLAV/Impound	--	--	--	--	--	--	--	--	--	(818)	--	(818)	(818)
Venue Payments	--	--	--	--	--	--	--	--	--	2,814	--	2,814	2,814
Bangor (Cytosporine)	--	--	--	--	--	--	--	--	--	2,400	--	2,400	2,400
Metabolites	--	--	--	--	--	--	--	--	--	(885)	--	(885)	(885)
Subtotal OTHER	28,750	11,535	40,275	373	1,207	1,580	27,127	14,735	61,434	41,197	18,043	59,130	19,344
Miscellaneous/Unidentified	--	--	--	--	--	--	41,777	2,415	44,192	2,220	--	2,220	(41,972)
TOTAL "OTHER"	--	--	--	--	--	--	88,900	17,220	88,170	45,417	18,043	83,132	(72,594)
-- Should be equal													
Blue Tied = Inputs													
All Other													
Hydrix	66	275	341	--	--	--	66	275	341	82	275	357	18
Macrolide AST787	--	--	--	--	--	--	--	--	--	25	--	25	25
Prokinetic Macrolide AST238	--	--	--	--	--	--	--	--	--	16	--	16	16
IQG AQ1959	5	--	5	--	--	--	5	--	5	97	--	97	92
Yucca AST271	--	--	--	--	--	--	--	--	--	14	--	14	14
FLAP AST240	22	--	22	--	--	--	22	--	22	114	--	114	92
Gramicidin AST822	--	--	--	--	--	--	--	--	--	1,242	--	1,242	1,242
Discovery	--	--	--	--	--	--	--	--	--	--	--	--	--
BAG1	--	--	--	--	--	--	--	--	--	--	--	--	--
HEART Metabolite Complications	--	--	--	--	--	--	--	--	--	--	--	--	--
Misc	--	--	--	--	--	--	--	--	--	--	--	--	--
Fenofibrate (Viscous)	--	--	--	--	--	--	--	--	--	90	--	90	90
Compliance Initiative	--	8,097	8,097	--	--	--	--	8,097	8,097	6,279	--	6,279	180
Pharmaceuticals	--	1,791	1,791	--	--	--	--	1,791	1,791	--	6,941	6,941	2,241
Total All Other	93	8,073	8,166	--	--	--	93	8,073	8,166	1,402	10,891	12,293	4,111

2001 PLAN Rollforward

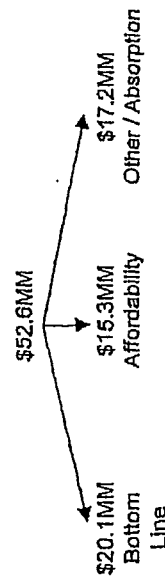
	Bottom Line	Other	Affordability
Book II	592.1	71.5	(25.1)
Re-prioritization	0	9.4 A	(2.6) B
Subtotal	592.1	80.9	(27.7)
Task Exercise	20.1	5.2 C	17.9 D
Final Plan	572.0	86.1	(9.8)

A Added \$12MM in grants and cut \$18.8MM in other. Projects cut (\$6.8MM) and functionals added \$2.6MM. This means absorption went up \$9.4MM.

B Functional impact was up \$12MM in grants and down (\$18.8MM / 2) = (\$9.4MM) in functionals \$12MM - \$9.4MM = \$2.6MM

C Projects cut \$55.0MM which translated into functional cuts of \$40.3MM. \$55.0MM - \$40.3MM = \$14.7MM of unabsorption. In addition to the unabsorption, relief was given by Commercial for Gabtril/Corp. Alloc for \$1.6MM, the Cyclosporine deal with SPD was terminated for an \$0.4MM, FTI #2 switch to KCO for (\$0.4MM), a change in the CMIS IDV for (\$0.4MM), elimination of Ketolide task 7.0MM, elimination of International Clari. charges for \$3.9MM, absorption changes of (\$13.1MM) and a change in affordability of (\$8.5MM).

D Of the \$40.3MM in functional cuts, we took \$20.1MM to the bottom line, therefore \$17.9MM went to reduce affordability



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Task Backup/ Rollforwards

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2001 Plan Task Exercise
Pharmaceutical Products Division
Research and Development
(\$MM)

Project Name	Project \$MM			Functional \$MM		
	Grants	Other	Total	Grants	Other	Total
- ABSINPS	-	7.0	7.0	-	3.5	3.5
- Ketolide	-	5.0	5.0	-	2.5	2.5
- BPH	6.4	19.0	25.4	6.4	9.5	15.9
- Kaletra	(7.8)	(1.6)	(9.4)	(7.8)	(0.8)	(8.6)
- Endothelin	(10.6)	(5.6)	(16.2)	(10.6)	(2.8)	(13.4)
- KCO	0.5	5.5	6.0	0.5	2.8	3.3
- Depakote New Formulations	-	1.8	1.8	-	1.0	1.0
- K5	-	8.8	8.8	-	4.4	4.4
- Cox II	-	3.0	3.0	-	1.5	1.5
- Clarithromycin: Cystic Fibrosis Asthma International	0.7	-	0.7	0.7	-	0.7
	2.4	-	2.4	2.4	-	2.4
	2.0	-	2.0	2.0	-	2.0
- Tricor - Diabetics	-	4.0	4.0	-	2.0	2.0
- ChCM	1.6	5.4	7.0	1.6	2.7	4.3
- Discovery	-	5.0	5.0	-	5.0	5.0
- IM&T	-	-	-	-	1.0	1.0
- Project Expense	-	-	-	-	1.0	1.0
Total Task	(4.8)	57.4	52.6	(4.8)	33.2	28.4

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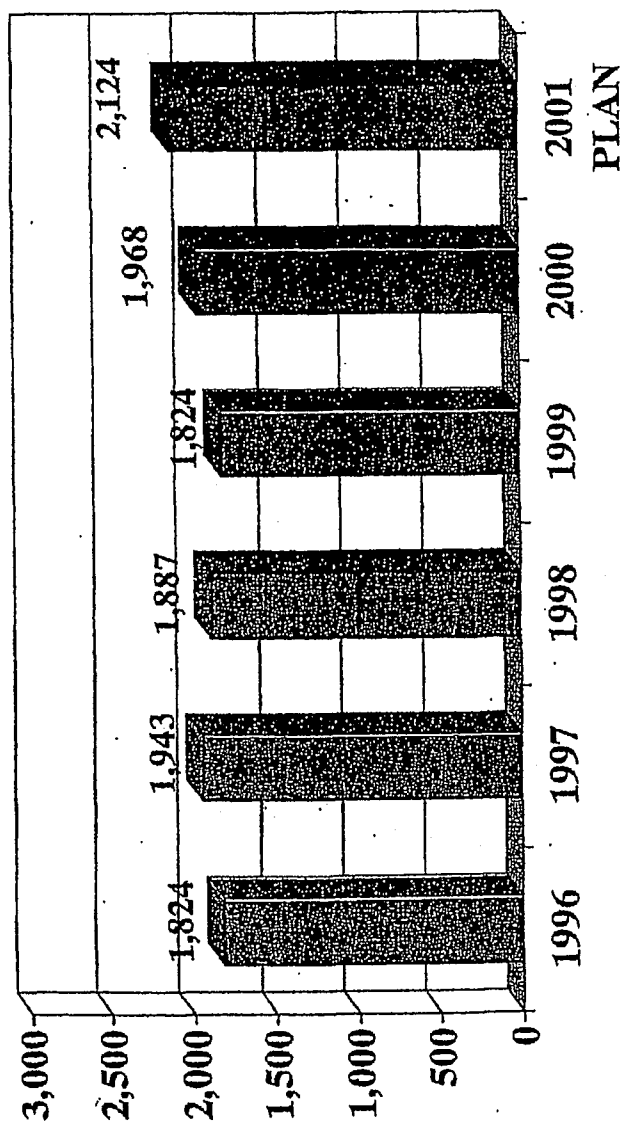
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Headcount

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R&D Regular Headcount 1996-2001



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2001 PLAN
Final PLAN vs AGU
YEAR END HEADCOUNT ANALYSIS

2001, PLAN
FINAL HEADCOUNT

	Book I AGU	Final (Oracle) AGU	Book I PLAN	Book II PLAN	Final (ORACLE) PLAN	Incr / (Decr) Final PLAN vs. Final AGU	Commentary
IS&T							
Net	298	232	284	264	257	(35)	+38 Regular, +1 Temp, -70 SciPro
Gross	298	238	284	264	257	(41)	
VENTURES							
Cardiovascular & Diabetes							
Net	0	0	0	0	0	0	
Gross	0	0	0	0	0	0	
Macrobids							
Net	41	41	48	48	42	1	+1 SciPro
Gross	41	41	48	48	42	1	
Anti-Viral							
Net	51	48	51	51	35	7	+7 Regular
Gross	55	53	55	55	57	2	
Analgesia							
Net	18	14	35	35	11	(3)	-2 Regular, +1 SciPro
Gross	18	16	35	35	11	(5)	
Urology							
Net	19	17	23	23	14	(5)	-1 Regular, -1 Contract, -1 SciPro
Gross	21	21	24	24	14	(7)	
Oncology / Transplant							
Net	35	36	38	38	47	11	+6 Regular, +1 Temp, +1 Contract, +3 SciPro
Gross	42	42	43	43	47	5	
Total Ventures							
Net	164	158	183	183	169	13	
Gross	177	175	203	203	171	(4)	
DISCOVERY							
Net	778	778	778	778	770	(8)	-8 Regular, -1 Temp, +3 Contract, +1 SciPro
Gross	802	802	803	803	803	1	
DRUG SAFETY							
Net	200	185	205	205	189	(9)	-3 Regular, -3 Contract
Gross	205	205	206	208	205	0	
PARC							
Net	344	330	344	344	337	7	+9 Regular, -2 Contractors
Gross	358	358	360	360	359	3	
PHASE I							
Net	57	50	78	78	82	8	+3 Regular, +3 Contractor
Gross	57	57	78	78	82	5	
DEV OPS							
Net	213	197	218	218	181	(16)	+2 Regular, -2 Temp, +6 Contract, -21 SciPro
Gross	213	213	220	220	188	(27)	
RA							
Net	57	54	59	59	58	4	+6 Regular
Gross	59	59	59	59	58	(1)	
MA							
Net	143	138	145	148	137	1	+4 Regular, -3 Contractor,
Gross	145	145	148	148	148	1	
ADMIN							
Net	88	82	85	85	113	31	+14 Regular, -1 Temp, +18 SciPro
Gross	88	82	85	85	113	31	
JUDGMENT							
Net	23	57	35	(4)	80	3	-28 Regular, +4 Temp, -1 Contract, +18 SciPro
Gross	35	41	51	7	73	32	
TOTAL							
Net	2,373	2,373	2,412	2,373	2,373	0	
Gross	2,443	2,443	2,487	2,443	2,443	0	

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R&D PERSONNEL - 2001 PLAN													
DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	12-Mo Avg
Actual													13-Mo Avg
REGULAR													
GROSS	1,888	2,180	2,170	2,175	2,167	2,162	2,146	2,145	2,153	2,181	2,178	2,174	2,194
UNFILL	---	(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(63)	(53)	(43)	(70)
NET	2,089	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124
TEMPORARY													
GROSS	13	21	21	21	21	34	56	56	50	22	22	22	22
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	13	21	21	21	21	34	56	56	50	22	22	22	22
CONTRACT													
GROSS	87	80	78	79	76	78	76	77	73	74	73	75	75
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	87	80	78	79	76	78	76	77	73	74	73	75	75
SCIENTIFIC													
GROSS	295	162	174	168	179	169	165	165	167	166	170	172	152
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	295	162	174	168	179	169	165	165	167	166	170	172	152
TOTAL EQUIV													
GROSS	395	263	273	268	276	281	297	298	290	262	265	269	249
UNFILL	---	---	---	---	---	---	---	---	---	---	---	---	---
NET	395	263	273	268	276	281	297	298	290	262	265	269	249
GRAND TOTAL													
GROSS	2,364	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443
UNFILL	---	(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(63)	(53)	(43)	(70)
NET	2,364	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373
Dly Contract	363	242	252	247	255	247	241	242	240	240	243	247	227

Monthly Changes												Total
J	F	M	A	M	J	J	A	S	O	N	D	
2,364	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443
(193)	(168)	(143)	(118)	(88)	(40)	(35)	(50)	(63)	(53)	(43)	(70)	(70)
2,364	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373

	Quarterly Changes					End
	Beg	I	II	III	IV	
2001 PLAN	2,364	(64)	103	(23)	(7)	2,373
2000 ACTUALS	2,308	(78)	17	(15)	132	2,384
1999 ACTUALS	2,457	(311)	31	44	87	2,308
1998 ACTUALS	2,535	(80)	13	(71)	70	2,457
1997 ACTUALS	2,532	(239)	44	88	110	2,535

Total Adds	
Regular	2,373
Equivalent	2,384
Unfills	2,308

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Manmonth) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
Information Management & Technology													
Regular	177	179	180	180	181	183	186	186	189	189	189	191	2,216
Temp/Summer	---	---	---	---	---	---	---	---	---	---	---	---	---
Contractors	---	---	---	---	---	---	---	---	---	---	---	---	---
Sci/Pro	78	79	74	72	72	72	71	71	70	69	67	66	861
Net Total	255	258	254	252	253	255	257	257	259	258	256	257	3,071
Unfills	---	---	---	---	---	---	---	---	---	---	---	---	---
Gross Total	255	258	254	252	253	255	257	257	259	258	256	257	3,071
Ventures													
Regular	138	140	140	143	146	147	147	147	147	147	147	147	1,736
Temp/Summer	3	3	3	3	3	3	3	3	3	3	3	3	36
Contractors	6	6	6	6	6	6	6	5	5	5	5	5	67
Sci/Pro	16	16	16	16	16	16	16	14	14	14	14	14	182
Net Total	163	165	165	168	171	172	172	169	169	169	169	169	2,021
Unfills	11	11	11	9	6	5	5	2	2	2	2	2	68
Gross Total	174	176	176	177	177	177	177	171	171	171	171	171	2,089
Discovery													
Regular	747	745	746	746	747	748	748	748	748	748	748	749	8,968
Temp/Summer	2	4	4	4	10	23	23	17	4	3	3	3	106
Contractors	20	20	20	19	19	19	18	17	17	17	17	17	220
Sci/Pro	1	1	1	1	1	1	1	1	1	1	1	1	12
Net Total	770	770	771	770	783	791	790	783	770	769	769	770	9,306
Unfills	33	33	32	33	32	31	31	33	33	34	34	33	392
Gross Total	803	803	803	803	815	822	821	816	803	803	803	803	9,698
Drug Safety													
Regular	179	180	184	184	184	184	184	184	184	184	184	184	2,199
Temp/Summer	---	---	---	---	---	13	13	13	---	---	---	---	39
Contractors	5	5	5	5	5	5	5	5	5	5	5	5	60
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	184	185	189	189	189	202	202	202	189	189	189	189	2,298
Unfills	21	20	16	16	16	16	16	16	16	16	16	16	201
Gross Total	205	205	205	205	205	218	218	218	205	205	205	205	2,499
Pharm Analytical R&D													
Regular	318	318	318	318	318	318	318	318	318	318	318	318	3,816
Temp/Summer	2	2	2	2	2	2	2	2	2	2	2	2	24
Contractors	17	17	17	17	17	17	17	17	17	17	17	17	204
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	337	337	337	337	337	337	337	337	337	337	337	337	4,044
Unfills	22	22	22	22	22	22	22	22	22	22	22	22	264
Gross Total	359	359	359	359	359	359	359	359	359	359	359	359	4,308
Phase-I Center													
Regular	48	49	50	53	53	53	53	53	53	53	53	53	624
Temp/Summer	2	2	2	2	2	4	4	4	4	2	2	2	32
Contractors	8	8	7	7	7	7	7	7	7	7	7	7	85
Sci/Pro	---	---	---	---	---	---	---	---	---	---	---	---	---
Net Total	58	59	59	62	62	64	64	64	64	62	62	62	742
Unfills	1	3	3	---	---	---	---	---	---	---	---	---	7
Gross Total	59	62	62	62	62	64	64	64	64	62	62	62	749

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Manmonth) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
Development Operations													
Regular	148	148	148	148	148	150	150	150	150	150	150	150	1,790
Temp/Summer	1	1	1	1	1	1	1	1	1	1	1	1	12
Contractors	8	8	8	8	8	8	8	8	8	8	8	8	96
Sci/Pro	22	22	22	22	22	22	22	22	22	22	22	22	264
Net Total	179	179	179	179	179	181	181	181	181	181	181	181	2,162
Unfills	7	7	7	7	7	5	5	5	5	5	5	5	70
Gross Total	186	186	186	186	186	186	186	186	186	186	186	186	2,232
Regulatory Affairs													
Regular	57	58	60	62	62	62	62	62	62	62	62	62	733
Temp/Summer	1	1	1	1	1	1	1	1	1	1	1	1	12
Contractors	4	4	4	4	4	4	4	4	4	4	4	4	48
Sci/Pro	1	1	1	1	1	1	1	1	1	1	1	1	12
Net Total	63	64	66	68	68	68	68	68	68	68	68	68	805
Unfills	2	1	...	...	...	...	...	...	...	...	...	...	3
Gross Total	65	65	66	68	68	68	68	68	68	68	68	68	808
Medical Affairs													
Regular	112	115	119	122	122	124	125	125	125	125	125	125	1,464
Temp/Summer	1	1	3	3	3	5	5	5	1	1	1	1	30
Contractors	7	7	7	7	7	7	7	7	7	7	7	7	84
Sci/Pro	5	6	6	6	6	5	4	4	4	4	4	4	58
Net Total	125	129	135	138	138	141	141	141	137	137	137	137	1,636
Unfills	17	13	10	9	9	9	9	9	9	9	9	9	121
Gross Total	142	142	145	147	147	150	150	150	146	146	146	146	1,757
Administration													
Regular	88	88	88	88	88	88	88	88	88	88	88	88	1,056
Temp/Summer	2	2	2	2	2	2	2	2	2	2	2	2	24
Contractors	5	3	5	3	5	3	5	3	4	3	5	5	49
Sci/Pro	18	18	18	18	18	18	18	18	18	18	18	18	216
Net Total	113	111	113	111	113	111	113	111	112	111	113	113	1,345
Unfills	...	...	...	...	...	...	...	...	...	...	...	...	...
Gross Total	113	111	113	111	113	111	113	111	112	111	113	113	1,345
Judgment													
Regular	(25)	(18)	(1)	5	45	49	49	42	54	61	67	57	385
Temp/Summer	7	5	3	3	4	2	2	2	4	7	7	7	53
Contractors	...	...	...	...	...	...	...	...	...	...	...	...	...
Sci/Pro	21	31	30	43	33	30	32	36	36	41	45	26	404
Net Total	3	18	32	51	82	81	83	80	94	109	119	90	842
Unfills	79	58	42	22	(24)	(48)	(53)	(37)	(24)	(35)	(45)	(17)	(82)
Gross Total	82	76	74	73	58	33	30	43	70	74	74	73	924
Total Plan Detail													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temp/Summer	21	21	21	21	34	56	56	60	22	22	22	22	368
Contractors	80	78	79	76	78	76	77	73	74	73	75	75	914
Sci/Pro	162	174	168	179	169	165	165	167	168	170	172	152	2,009
Net Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Gross Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316

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Pharmaceutical Products Research & Development
2001 Plan Headcount (Manmonth) Summary

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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Man Months
From Heads Tab													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temporary/Summ	21	21	21	21	34	56	56	50	22	22	22	22	368
Contractors	85	83	85	85	85	84	86	84	85	84	85	85	1,016
Sci/Pro	157	169	162	170	162	157	156	156	155	159	162	142	1,907
Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316
Detail > Corp Submission													
Regular	---	---	---	---	---	---	---	---	---	---	---	---	---
Temporary/Summ	---	---	---	---	---	---	---	---	---	---	---	---	---
Contractors/Sci Pr	---	---	---	---	---	---	---	---	---	---	---	---	---
Total	---	---	---	---	---	---	---	---	---	---	---	---	---
Unfills	---	---	---	---	---	---	---	---	---	---	---	---	---
Total	---	---	---	---	---	---	---	---	---	---	---	---	---
2001 Corp Submission													
Regular	1,987	2,002	2,032	2,049	2,094	2,106	2,110	2,103	2,118	2,125	2,131	2,124	24,981
Temporary/Summ	21	21	21	21	34	56	56	50	22	22	22	22	368
Contractors/Sci Pr	242	252	247	255	247	241	242	240	240	243	247	227	2,923
Total	2,250	2,275	2,300	2,325	2,375	2,403	2,408	2,393	2,380	2,390	2,400	2,373	28,272
Unfills	193	168	143	118	68	40	35	50	63	53	43	70	1,044
Total	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	2,443	29,316

Oracle Report 01/31/01

Regular	2,012	2,020	2,033	2,051	2,049	2,057	2,069	2,061	2,061	2,064	2,064	2,087	24,608
Temporary/Summ	14	16	18	18	30	54	54	54	48	18	15	15	354
Contractors	80	78	79	76	78	76	77	77	73	74	75	75	918
Sci/Pro	141	143	138	135	136	135	133	133	131	130	127	126	1,608
Total	2,247	2,257	2,268	2,280	2,293	2,322	2,333	2,325	2,313	2,286	2,281	2,283	27,488
Unfills	114	110	101	89	92	88	79	88	87	87	88	87	1,110
Total	2,361	2,367	2,369	2,369	2,385	2,410	2,412	2,413	2,400	2,373	2,369	2,370	28,598

Check figure Oracle vs details before judgement

Regular	---	---	---	7	---	---	8	---	(3)	---	---	---	12
Temporary/Summ	---	---	---	---	---	---	---	6	30	3	---	---	39
Contractors	---	---	---	---	---	---	---	4	(1)	1	---	---	4
Sci/Pro	---	---	---	(1)	---	---	---	2	1	1	---	---	3
Total	---	---	---	6	---	---	8	12	27	5	---	---	58
Unfills	---	---	---	(7)	---	---	(9)	1	---	(1)	---	---	(16)
Total	---	---	---	(1)	---	---	(1)	13	27	4	---	---	42

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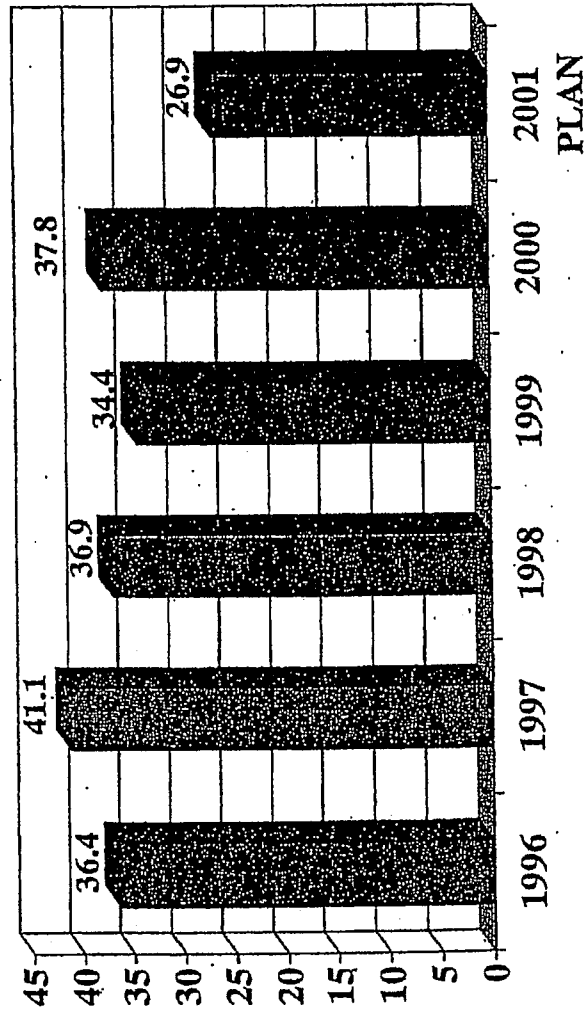
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Capital

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R&D Capital 1996-2001 (\$MM's)



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*Final
Plan*

2001 PLAN Capital
Pharmaceutical Products Research & Development

	2000 AGU	2001 PLAN	\$ Fav/(Unfav)	% Fav/(Unfav)
Authorizations				
IM&T	6,872	4,748	1,924	28.5%
Discovery	11,288	7,626	3,642	32.3%
Drug Safety	3,520	3,125	395	11.2%
PARO	3,485	5,805	(2,320)	-66.6%
Admin	12,380	3,480	8,810	71.9%
Dev Ops	100	100	0	0.0%
Medical Affairs	50	50	0	0.0%
RA/QA	10	10	0	0.0%
Other	283	2,000	(1,717)	-606.7%
Total	37,778	28,844	10,834	28.7%

Project Expense				
IM&T	8,831	2,080	6,541	75.8%
Discovery	1,095	892	203	18.5%
Drug Safety	272	17	255	93.8%
PARO	425	828	(403)	-84.8%
Admin	1,498	743	756	50.4%
Dev Ops	8	8	0	0.0%
Medical Affairs	11	11	0	0.0%
RA/QA	4	4	0	0.0%
Other	4	0	4	100.0%
Judgment	(1,722)	400	(2,122)	123.2%
Total	10,228	4,884	5,234	51.2%

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**PHARMACEUTICAL PRODUCTS DIVISION
RESEARCH & DEVELOPMENT
PROPOSED CAPITAL PROJECTS <\$250M**

	2000 AGU	2001 Authorizations		01 Funded v. '00 AGU
		Requests	Funded	
IM&T *	3,196	3,787	2,538	658
Development Ops	100	100	100	0
Discovery	4,670	4,027	4,027	643
Drug Safety	2,050	2,809	2,050	0
PARD	2,455	3,092	2,455	0
Medical Affairs	50	45	50	0
RA/QA	10	20	10	0
Other	283	0	2,000	(1,717)
Total	12,814	13,880	13,230	(416)
			(2,000)	650

* Includes \$1,545M for PC refresh and new employees.

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2001 Plan Task Exercise Pharmaceutical Products Division Research and Development (\$MM)				Capital Authorizations			Prod Expense		
				> 250	< 250	Total	> 250	< 250	Total
Capital Projects									
Project Name	Capital Auth	Project Exp	Commentary						
Admin:									
- Delay AEGIS Wave III to 2002	2,000	-							
- Reduce lab renovations	2,000	440							
Subtotal Admin	4,000	440							
IM&T:									
- Reduce FO Refresh/ Asset Mgmt	400	-							
- NT Storage Mgmt	854	154							
- Under \$250 project expense reduced	-	442							
Subtotal IM&T	1,254	598							
Discovery:									
- Therapeutic Area Projects Support	188	1,662							
- HTS Expansion	1,030	300							
- Genomics Expansion	680	460							
- Bring under \$250 back to original request amount	643	-							
- Under \$250 project expense reduced	-	200							
Subtotal Discovery	2,461	2,622							
Drug Safety:									
- LCMS	1,810	120							
- Lab Renovation AP13A	-	-							
- Gene Expression	411	1,044							
- Under \$250 project expense reduced	-	-							
Subtotal Drug Safety	2,321	1,164							
F&D:									
- Patent Drug Encapsulator	500	100							
- Under \$250 project expense reduced	-	400							
Subtotal F&D	500	500							
Other:									
- Eliminate Judgment	263	478							
- Unidentified Reversal Task	(2,000)	(400)							
Total Impact	8,559	6,800							

LCH1010 Public Comment 1/20/01 Times 2/2/01

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Balance Sheet

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ance Sheet Gating Bu. note this is exactly as it appears in the J20 drive

PHARMACEUTICAL PRODUCTS DIVISION
DETAIL OF ACCOUNTS PAYABLE, ACCRUED EXPENSES

book II 603

CATEGORY	Actual 12/31/07	Actual 12/31/06	Actual 12/31/05	AGU 12/31/00	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	13 MO AVG
SALARIES, WAGES & COMMISSIONS																	
Mgmt Incentive plans - RAD	(2,990)	(2,990)	(4,051)	(3,222)	(3,772)	(5,554)	(764)	(1,003)	(1,269)	(1,419)	(1,704)	(2,014)	(2,265)	(2,516)	(2,716)	(3,022)	(2,440)
OTHER ACCRUED LIABILITIES																	
Clinical trials - RAD	(75,827)	(67,790)	(316,947)	(54,798)	(86,160)	(62,290)	(84,128)	(62,437)	(81,651)	(91,201)	(83,616)	(19,488)	(16,151)	(43,529)	(44,717)	(43,761)	(53,284)
Drug Safety Grant Award - RAD	(448)	(505)	(672)	(504)	(896)	(596)	(950)	(646)	(854)	(866)	(863)	(566)	(889)	(589)	(686)	(589)	(591)
Misc RAD	(8,241)	(6,811)	(6,742)	(6,007)	(11,102)	(10,037)	(10,369)	(9,351)	(11,027)	(10,061)	(11,320)	(12,794)	(10,161)	(12,271)	(11,841)	(7,394)	(10,285)
OTHER ACCRUED LIABILITIES																	
	(66,247)	(63,940)	(160,352)	(64,327)	(85,835)	(72,878)	(79,104)	(72,774)	(79,264)	(72,160)	(83,711)	(82,818)	(59,678)	(87,482)	(59,924)	(51,972)	(64,163)
TOTAL AP & ACCRUED EXP.	(89,207)	(86,481)	(419,383)	(87,279)	(73,110)	(78,403)	(78,855)	(73,776)	(74,525)	(71,640)	(87,457)	(84,332)	(89,144)	(80,000)	(82,684)	(84,914)	(88,809)

PHARMACEUTICAL PRODUCTS DIVISION
DETAIL OF PREPAID EXP. AND OTHER RECEIVABLES

CATEGORY	Actual 12/31/07	Actual 12/31/06	Actual 12/31/05	AGU 12/31/00	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	13 MO AVG
PREPAID EXPENSE																	
Spandachange parts (RAD)	464	414	435	422	432	432	432	432	432	432	432	432	432	432	432	432	432
Ligand Contract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tagabine Reserve	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical R & D	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL PREPAID EXPENSE	464	414	435	422	432	432	432	432	432	432	432	432	432	432	432	432	432
OTHER RECEIVABLES																	
Travel advance (RAD)	673	305	170	325	576	576	576	576	576	576	576	576	576	576	576	576	509
TOTAL PREPAID AND OTHER RECEIVABLE	1,037	719	605	747	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	1,008	941

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JINICAL GRA: ALANCE SHEET GAITING
 PRD 348-300
 101 PLAN

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
ignnling G/L Balance	(53,000)	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(48,488)	(46,131)	(43,825)	(44,717)	
yments	8,945	8,867	11,077	11,788	11,421	10,547	12,283	9,231	9,461	9,383	8,781	10,754	122,556
ailed Grants (per P&L gaiting)	(14,095)	(12,873)	(12,846)	(10,606)	(10,235)	(10,397)	(4,597)	(4,884)	(8,124)	(7,087)	(9,673)	(9,788)	(113,317)
Grant Gaiting Adjustments													
ljusted Grants	(14,095)	(12,873)	(12,846)	(10,508)	(10,235)	(10,397)	(4,597)	(4,884)	(8,124)	(7,087)	(9,673)	(9,796)	(113,317)
her	...	...	...	...	...	...	...	...	...	...	...	...	...
iding G/L Balance	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(48,488)	(46,131)	(43,825)	(44,717)	(43,781)	
indposallings :													
lebit Balances	...	...	...	...	...	...	...	...	...	...	...	...	...
Other	...	...	...	...	...	...	...	...	...	...	...	...	...
iding MIFRP Balance	(58,150)	(62,256)	(64,128)	(62,837)	(61,651)	(61,501)	(53,815)	(48,488)	(46,131)	(43,825)	(44,717)	(43,781)	

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 3GROUP/PLANNING/2001 PLAN/Balance Sheet(Bal_act/Ltdw/grants)

96 Actual Pay as % of BB	22.25%	18.15%	30.89%	15.59%	20.70%	10.84%	25.05%	18.13%	20.28%	13.89%	21.79%	22.13%	
97 Actual Pay as % of BB	12.28%	6.62%	10.12%	14.98%	22.46%	11.46%	11.21%	12.60%	7.44%	8.08%	8.81%	14.55%	
98 Actual Pay as % of BB	3.62%	7.21%	5.93%	7.71%	9.64%	10.15%	9.46%	5.78%	8.88%	11.16%	8.88%	18.24%	
99 Actual Pay as % of BB	10.49%	10.81%	8.16%	19.70%	4.48%	18.73%	17.90%	12.52%	18.58%	25.64%	18.05%	20.91%	
our year average	12.16%	10.85%	13.78%	14.50%	14.20%	13.05%	15.91%	12.51%	14.07%	14.94%	14.33%	18.46%	
96 Actual	18,915	25,781	25,749	26,740	25,881	31,230	29,251	27,202	25,938	25,579	24,839	24,888	
97 Actual	40,699	48,087	48,433	48,752	44,188	47,580	50,515	55,855	62,751	64,408	67,078	75,827	
98 Actual	78,671	78,485	78,324	78,977	75,387	70,808	69,331	68,681	65,681	66,716	67,780	60,600	
99 Actual	67,702	67,392	58,501	51,012	49,767	47,310	39,852	33,259	34,582	36,331	40,172	43,840	
our year average	48,997	61,836	53,252	51,370	48,608	49,235	47,237	45,748	47,238	46,258	46,720	51,264	

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Depreciation

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Pharmaceutical Products Division R&D
2001 Depreciation Estimate vs. 2000 Depreciation
By Division.

Division	2001 Est. Base Depr.	2001 Estimated Depr. of Projects from 5/00-12/00	2001 Estimated Depr. for '01 Transfer	Judgement	2001 Est. Total Depr.	2000 Depreciation	\$ Inc/(Dec)	% Inc/(Dec)
42-IM&T	4,385	1,056	285	(134)	5,592	6,253	(661)	-10.8%
43-Ventures	293	24	8	(5)	318	276	43	15.6%
44-Discovery	11,103	1,756	688	(383)	13,165	12,906	259	2.0%
46-Drug Safety	2,703	23	482	(258)	2,950	3,046	(96)	-3.2%
47-PARD	3,721	235	270	(206)	4,020	4,428	(408)	-9.2%
49-Phase I Center	244	2	9	(7)	248	205	43	21.0%
52-Development Ops.	1,535	1	10	(8)	1,538	1,405	133	8.5%
53-RAVQA	80	8	4	(4)	88	30	58	44.1%
54-Medical Affairs	208	8	8	(8)	220	182	38	20.9%
55-Admin	448	2,699	43	(33)	3,157	2,031	1,126	55.4%
	<u>24,730</u>	<u>5,813</u>	<u>1,808</u>	<u>(1,043)</u>	<u>31,307</u>	<u>30,800</u>	<u>507</u>	<u>1.7%</u>

* Based on the FAR 50 Report dated 5/00.

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Floorspace

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**PFD R&D
DIVISIONAL VARIANCE SUMMARY
2001 PLAN
FLOORSPACE**

Division	Total Dollars (\$000's)		% Inc/Dec	Total Square Feet		% Inc/Dec	Average Rate		% Inc/Dec
	2000	2001		2000	2001		2000	2001	
IMBT	1,884.4	1,828.9	44.5	50,847	50,792	(55)	\$37.08	\$37.88	90.82
Venires	1,051.3	1,016.4	(34.6)	28,828	28,878	(2,250)	\$36.54	\$36.10	\$1.76
Discovery	18,520.8	18,520.7	883.8	364,862	365,516	553	\$50.78	\$50.41	\$2.64
PARC	7,882.9	7,900.3	28.4	144,747	144,747	(1,181)	\$51.88	\$51.84	\$2.68
Pharm Center	5,855.2	6,164.8	286.4	144,888	144,888	(279)	\$40.42	\$42.37	\$2.18
Development Ops	286.9	301.2	14.4	4,880	4,880	0	\$61.17	\$64.23	\$3.06
Regulatory Affairs	1,441.1	1,357.7	(83.5)	38,734	33,838	(4,796)	\$37.21	\$40.00	\$2.80
Medical Affairs	434.8	464.4	25.7	12,135	12,375	240	\$35.82	\$37.52	\$1.71
Administration	555.8	676.8	118.0	17,204	18,058	1,852	\$32.82	\$35.81	\$2.98
	443.1	702.7	259.8	10,184	15,556	5,472	\$43.59	\$44.88	\$3.04
Late Charge Point	(351.7)	(340.5)	8.2	..	..	..	N/A	N/A	N/A

(a) Primarily due to Clinical Pharmacokinetics (D-474) receiving 1,107 sq. ft. in AP9 for 2001 PLAN.
 (b) Primarily due to Statistics (D-439) re-allocating their space to Outcomes research (D-42), Med. Affairs and Decision Analysis (D-4NP, Admin.).
 (c) Primarily due to R&D Ops (D-477) receiving and additional 644 sq. ft. in AP9A and due to Outcomes Research (discussed in footnote (b) above).

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**PPD R&D
BUILDING VARIANCE SUMMARY
2001 PLAN
FLOORS/SPACE**

Building	Total Dollars (\$000's)		% Inc/Dec	Total Square Feet		% Inc/Dec	Average Rate		% Inc/Dec
	2000	2001		2000	2001		2000	2001	
A1	11.9	12.8	6.0%	364	364	0.0%	\$32.68	\$1.86	5.0%
A4	231.1	242.2	4.8%	6,359	6,359	0.0%	\$36.10	\$1.75	4.8%
AP10	4,900.3	5,124.0	4.5%	101,284	101,284	(4)	\$50.59	\$2.18	4.5%
AP13	1,740.0	1,812.8	4.2%	35,503	(100)	(0.3%)	\$51.09	\$2.20	4.6%
AP13A	4,489.7	4,722.8	5.0%	73,523	(31)	(0.0%)	\$61.23	\$3.08	5.0%
AP15	151.0	165.4	9.5%	11,931	12,273	342	\$13.46	\$0.82	8.5%
AP16A	134.0	131.1	(2.2%)	5,080	4,418	(642)	\$26.48	\$3.18	12.0%
AP20	163.5	172.5	5.5%	3,861	3,861	0.0%	\$42.35	\$2.33	5.5%
AP3	853.2	925.5	8.5%	25,885	29,885	0	\$34.12	\$1.76	5.2%
AP30	930.2	875.2	(5.9%)	25,596	25,596	0	\$36.10	\$1.76	4.8%
AP31	881.5	807.9	(8.3%)	14,784	14,784	0	\$59.49	\$1.14	5.4%
AP34	257.7	266.4	3.3%	6,942	6,762	(180)	\$36.10	\$1.76	4.8%
AP52	5,095.9	5,375.6	5.5%	85,763	85,753	(10)	\$59.42	\$2.28	5.5%
AP6A	496.0	629.3	26.3%	13,825	13,868	(69)	\$36.10	\$1.76	4.8%
AP6B	632.1	672.4	6.3%	22,897	22,897	0	\$36.10	\$1.76	4.8%
AP6C	53.5	50.0	(6.5%)	1,476	847	(1,440)	\$36.10	\$1.76	4.8%
AP80	25.3	32.3	27.7%	697	847	150	\$36.10	\$1.76	4.8%
AP8	3,066.8	3,822.1	24.6%	83,702	83,702	0	\$36.10	\$1.76	4.8%
AP9	4,388.3	4,747.3	8.2%	100,702	100,690	(112)	\$43.35	\$2.60	6.0%
AP9B	168.3	168.3	0.0%	10,752	10,752	0	\$43.35	\$2.60	6.0%
AP9C	463.1	427	(7.8%)	2,769	2,769	0	\$14.45	\$0.67	0.0%
J2	185.1	185.2	0.1%	7,323	7,323	0	\$25.28	\$0.42	1.7%
J25 (Ambul)	272.3	276.8	1.6%	10,777	10,777	0	\$25.28	\$0.42	1.7%
J26 (North Point-MIS)	408.8	405.3	(0.9%)	12,262	12,262	0	\$25.28	\$0.42	1.7%
J36 (Carriage Path)	351.7	343.5	(2.3%)	N/A	N/A	N/A	\$33.34	(40.20)	(0.6%)
M2	28.8	30.5	5.9%	1,168	1,168	0	N/A	N/A	N/A
M3	611.3	637.2	4.2%	32,742	31,970	(772)	\$24.48	\$1.65	6.7%
R1	168.9	161.0	(4.6%)	6,035	4,671	(364)	\$18.67	\$1.28	5.7%
R12	353.9	399.8	13.0%	6,731	8,731	2,000	\$51.76	\$3.47	4.0%
R13	2,854.5	2,863.0	0.3%	46,671	45,971	(700)	\$61.46	\$2.62	4.3%
R14	676.8	597.3	(11.8%)	12,637	12,696	(41)	\$54.54	\$2.41	7.0%
R18	1,041.3	1,215.8	16.8%	26,660	28,807	2,147	\$39.04	\$2.54	6.5%
R2	331.4	357.4	7.8%	8,548	9,868	1,320	\$38.44	\$1.74	5.0%
RE	639.6	673.5	5.3%	15,914	15,915	1	\$40.77	\$2.11	4.0%
Less Carriage Point	(351.7)	(343.5)	(2.3%)	--	--	--	N/A	N/A	N/A

MEMO:	Increased by 5.3%
CEC Rate	Increased by 1.6%
Amort Rate	Decreased by 0.6%
North Point Charges	Decreased by 2.3% due to commercial assuming responsibility for R&D sq. ft. more over year 2000.
Carriage Point Charges	

- (a) Primarily due to PARD's Intermediate Scale Up facilities (D-49) accounting for 488 sq. ft. and \$0.6 over year 2000.
 (b) Primarily due to PARD's Intermediate Scale Up facilities (D-49) taking less space in AP16A and more in AP18.
 (c) Due to Onuma Research (D-42) no longer needing D-49 space.
 (d) Primarily due to an increase in space on the 2nd floor (D-43). Amount will reside in D-45A until floor plan can be updated.
 (e) Carriage Point Charges for R12 increased by 25,000 sq. ft. in 2001.
 (f) Primarily due to PARD's Intermediate Scale Up facilities (D-49) accounting for 25,000 sq. ft. in 2001.
 (g) Primarily due to PARD's Intermediate Scale Up facilities (D-49) accounting for 25,000 sq. ft. in 2001.
 (h) Primarily due to PARD's Intermediate Scale Up facilities (D-49) accounting for 25,000 sq. ft. in 2001.
 (i) Due to PARD's Pharm. Analysis & Synthesis occupying more space.

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**Misc. Fixed Expenses
(Burden File)**

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PPD R&D
2001 Fixed Allocations/Charges
GROSS (\$000)

Direct to Departments (Stack Card)	2000 AGU	2001 Plan	2001 APU	2001 AGU	01 Plan I(D) vs. '00 AGU \$	%	Notes
PPNC Allocations							
11 Wisdom to Product Development and RA/Q	328.7	322.7	322.7	322.7	-6.0	-1.8%	PPD Ops Fixed (T. Dee / J. Truax)
12 Other to Product Development	2,031.0	3,044.6	3,044.6	3,044.6	1,013.6	49.9%	PPD Ops Fixed (T. Dee / J. Truax)
13 Housekeeping	187.1	187.1	187.1	187.1	0.0	0.0%	Pulls from Misc. Fixed Tab
14 Whse. Handling Fixed Allocation	0.0	86.5	86.5	86.5	86.5	#DIV/0!	Pulls from Misc. Fixed Tab
Other							
15 Amortization Svc Loaners	28.5	28.5	28.5	28.5	0.0	0.0%	Pulls from Misc. Fixed Tab
16 Utilities	98.6	98.5	98.5	98.5	-0.1	-0.1%	Pulls from Misc. Fixed Tab
17 Corp Copier Fixed Costs	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
18 R&D Internal Allocation	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
19 ABC Allocations	0.0	0.0	0.0	0.0	0.0	0.0%	Pulls from Misc. Fixed Tab
Subtotal PPNC/Other	2,672.9	3,766.9	3,766.9	3,766.9	1,094.0	40.9%	
Corporate Reallocations							
3 Subtotal Other Cost Expense Pools	n/a	n/a	n/a	n/a	#VALUE!		N/A
R&D Allocations							
Depn Depreciation	32,662.8	31,308.5	31,308.5	31,308.5	-1,354.1	-4.1%	L:\GROUP\PLANNING\2001 PLAN\FloorSpace\01floor.xls
Depn Floor Space	37,328.0	40,013.1	40,013.1	40,013.1	2,684.1	7.2%	L:\GROUP\PLANNING\fixedexp\01fixed\blm depr.wk4
Total Fixed (Group 40 for Functionals)	<u>72,664.5</u>	<u>75,088.5</u>	<u>75,088.5</u>	<u>75,088.5</u>	<u>2,424.0</u>	<u>3.3%</u>	
20 Total Cost Assignments Absorbed in Overh	42,244.6	40,081.1	40,081.1	40,081.1	-2,163.4	-5.1%	
Total Fixed/Overhead	<u>114,909.0</u>	<u>115,169.6</u>	<u>115,169.6</u>	<u>115,169.6</u>	<u>260.6</u>	<u>0.2%</u>	

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	PPD ALLOC	- SUMMARY FUNCTIONAL & C	-HEAD EXPENSE GROSS (\$000)
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Note: These charges are obtained from various memos (mainly from PPD Ops). These memos are detailed in the Fixed Expenses binder. All PARO expenses come from Steve Swastik directly (those should be in line with what PPD Ops has submitted (via J. Trusz).

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Fixed Allocations from Operations

(Via J. Triax memo)

		2000	2001	PD Variances		RD Variances	
		Product Research Develop & Develop	Product Research Develop & Develop	\$	%	\$	%
PD RD							
11	WISDOM(On-Going)	189,000	183,000	-6,000	-3.2%	-50	0.0%
	EDMS (On Going)	255,000	255,000				
	EDMS Project Expense	85,000	0				
12	D-44K Stability (DOF)	75,000	75,000	0	0.0%	84,400	19.2%
12	D-44K Utilities	48,000	104,600	56,600	117.9%	-46,200	-19.7%
12	CHEN Maintenance	208,000	472,000	264,000	126.9%	-48,000	-5.1%
12	PA ABC Allocations	682,000	776,000	98,000	14.1%	-75	-0.1%
12	QA ABC Allocations	978,000	1,320,000	342,000	35.0%	504,000	35.0%
	CAPD Warehouse/Waste	83,648	81,773	0	0.0%	-1,875	-2.2%
28	CAPD Project Exp. Transfer	105,000	105,000	0	0.0%	0	0.0%
25	D-55A Engineering Support	288,000	375,000	0	0.0%	107,000	39.9%
21	Corp. Eng. Proj. Expense	1,426,000	1,993,000	0	0.0%	567,000	39.8%
12	D-55T Calibration Service	40,000	40,000	0	0.0%	0	0.0%
	CHEN Envir Health & Saf	0	0	0		0	
28	Total	2,660,000	3,227,600	567,600	26.1%	39,000	7.0%
				6,814,623		1,205,200	21.1%

a) Not Included in overhead; charged directly to projects.

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Key Unfunded List

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PPD - Research and Development
2001 PLANKey Unfunded Projects
(\$MM's)

(As of 11/5/2001)

Drug/Compound	Project Description	2001 PLAN
NEUROLOGY		
Depakote	New Formulations (Epilepsy & Acute Migraine)	1.9
Depakote	Bipolar in Pediatric Males	1.4
ABT-594	Post Milestone Funding (3rd and 4th Quarter)	9.8
ABT-594	Phase IIB Osteoarthritis Study (assumes 1/1/01 start date)	5.8
ABT-594	Additional Acute Pain Study (Phase IIB Molar Extraction Study)	3.0
COX-II	Ongoing Pre-Clinical Studies	3.0
ABT-089	Single/Multiple Rising Dose Phase I Study	7.0
ABS-100	Pre-Clinical Studies	3.3
ABS-100	Single Rising Dose Phase I Study	2.4
NPS-1778	Pre-Clinical Studies	3.7
NPS-1778	Single and Rising Multiple Phase I and Formulation Bio Studies	2.4
Subtotal NEUROLOGY		43.7
ANTI-INFECTION		
Clarithromycin	Asiana/Immunomodulatory Studies	2.4
ABT-773	ABT-773 IV Development Cost	8.0
Quinolone (ABT-432)	Phase II Acceleration/Expansion of Clinical Studies	9.7
Quinolone (ABT-432)	IV Formulation	4.0
Quinolone (ABT-432)	Japan Phase I Study	1.0
Ornidazole	Pharyngitis/Tonsillitis Study: Pediatrics, Suspension, 50 BID vs. Ziltronax	4.0
Ornidazole	ABECB - Two Arm Study 50 QID vs. Comparator	2.4
Subtotal ANTI-INFECTION		31.5
UROLOGY		
Fosfibrate	Diabetics	4.0
Bimodermal	Phase III Studies	10.0
KCO	Pre-Clinical/Phase I Studies	6.0
Subtotal UROLOGY		20.0
HIV/IMMUNOLOGY		
Kaletra	Phase IIB Program (unfunded portion)	5.8
Kaletra	Kaletra QD	4.2
Kaletra	Post Approval Commitments	4.2
Kaletra	Kaletra Salvage	2.8
Kaletra	Kaletra Firstline	2.6
Kaletra	Expanded Access Program	1.0
Kaletra	Phase IV RTI	1.3
Kaletra	WHSC Cohort	1.0
Kaletra	Metabolites Program	0.8
Kaletra	Miscellaneous Phase IV Studies	0.7
Subtotal HIV/IMMUNOLOGY		24.8
ONCOLOGY		
ABT-527	Early Stage Pca Cancer	11.0
K-5	Pre-Clinical/Phase I Studies	8.8
Subtotal ONCOLOGY		19.8
DISCOVERY		
DDC's	Development of DDC's	7.7
UNLICENSED COMPOUNDS		
Various	Funds to Acquire New Compounds	7.7
PRODUCTIVITY		
30% Reduction in Capital	Productivity Projects	6.0
	Rosetta Gene Expression	
	Genomics/HTS Expansion Program	
	AEGIS MedORA	

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Subject Proposed APU Target Adjustments

Attached please find my proposed adjustments to APU targets based on 1) Review of detail budget info in Oracle and 2) based on issues that have come in in the APU Review process (e.g. Kaletra PARD increase, Endothelin CRO savings, etc.).

I would appreciate it if each of you can review (analysts please review your respective projects). I think the most "controversial" proposal is increasing the 773 target by \$1.6MM. Bill I would appreciate it if you could do a scrub of Oracle upon your return from vacation. I noticed that your development cost summary reflects different numbers than currently in Oracle (incidentally the \$1.2MM SPD reduction needs to get dialed into Oracle). At a minimum, we should increase the 773 target for the IV Phase I study.

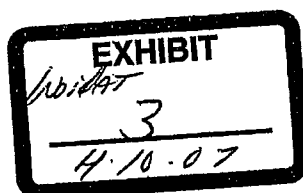
Let me know your comments.

Tom



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2001 APRIL UPDATE
GLOBAL PHARMACEUTICAL RESEARCH & DEVELOPMENT
KEY PROJECT SUMMARY
(\$MM)

Actuals thru 2000	FRANCHISES	2001 PLAN	2001 APU	Proposed Adjust	2001 APU REVISED	APU vs PLAN Fav/(Unfav)	COMMENTS
	NEUROLOGY						
178.9	Depakote	24.1	24.1	(0.8)	23.5	0.6	Lower Impulsive Aggression costs
106.5	Gabril	1.4	1.4		1.4		No target incr - assume risk of \$0.5MM for CRD payment
62.2	ABT-594 (formerly CCM)	9.3	9.3		9.3		
2.7	COX - II (ABT-963)	1.2	1.2	0.1	1.3	(0.1)	PARAD stability \$2MM (\$3 to confirm amt), offset by target adj
1.6	ABT-089 (formerly ChCM)	0.6	0.6	0.3	0.9	(0.3)	PARAD stability (\$3 to confirm amt)
	ABS-103	-	-		-		
	NPE-1778	4.0	4.0		4.0		
	RP Scherer / Alza (Hydrocodone)	-	-		-		
362.9	Subtotal NEUROLOGY	40.6	40.6	(0.2)	40.4	0.2	
	ANTI INFECTIVE						
993.8	Clarithromycin	14.9	14.9		14.9		\$0.5MM of task required to achieve target
153.0	Ketolide (ABT-773)	88.0	88.0	1.6	89.6	(1.6)	Fund IV form Ph I \$0.5MM and adj target to detail budget
11.6	Quinolone (ABT-492)	24.6	24.6	(0.2)	24.3	0.2	Adj target to detail budget
	Neuraminidase (ABT-677)	-	-		-		
	Omnicef	4.9	4.9	(0.1)	4.8	0.1	Adj target to detail budget
559.2	Subtotal ANTI INFECTIVE	132.3	132.3	1.3	133.6	(1.3)	
	UROLOGY/CARDIOLOGY						
85.7	BPH Backup (ABT-980)	2.3	2.3		2.3		
14.1	Fenofibrate (Fournier)	1.4	1.4	0.6	2.0	(0.6)	Continue PARAD stability work (not in 01 Plan target)
12.3	Nippon Shinyaku (NS-49)	-	-		-		
	KCO (ABT-598)	5.0	5.0		5.0		
112.1	Subtotal UROLOGY/CARDIOLOGY	8.7	8.7	0.6	9.3	(0.6)	
	HIV						
299.3	Ritonavir	4.0	4.0	0.2	4.2	(0.2)	Wartarin Interaction Study (EU Registration)
215.7	Kaletra	51.0	51.0	1.0	52.0	(1.0)	Stability & Dissolution issues; target with reflects \$1.2MM task
81.0	Cyclosporine	2.5	2.5		2.5		Target reflects \$282M task judgments
576.0	Subtotal HIV	57.5	57.5	1.2	58.7	(1.2)	
	CANCER						
96.4	Endothelin (ABT-527)	38.5	38.5	(0.4)	38.4	0.4	Primarily Phase III CRD savings - 5MM
11.0	TSP #1 (ABT-510)	10.0	10.0	0.6	10.6	(0.6)	SPD increase (offset in Other-Pilot Plan Escrow Cap)
6.6	Metalloproteinase (ABT-518)	7.4	7.4	(0.1)	7.3	0.1	
3.8	Ani-Mitosis (ABT-751)	0.4	0.4	(0.1)	0.3	0.1	
1.0	K-5 (ABT-828)	-	-		-		
	FTI #2	-	-		-		
117.9	Subtotal CANCER	64.6	64.6	(0.0)	64.6		
n/a	Other	86.1	86.1	(2.8)	83.2	2.9	
n/a	Affordability	(9.8)	(9.8)		(9.8)		
n/a	Total Development	380.0	380.0	0.0	380.0	0.0	
n/a	Discovery	192.0	192.0		192.0		
n/a	Total Global R&D	572.0	572.0	0.0	572.0	0.0	
n/a	KNOLL Projects*	n/a	263.0	263.0	263.0	n/a	

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*****	Total Q104	*****	*****	*****	*****
*****	*****	*****	*****	*****	*****

*Knoll Project detail is located in the Knoll tab of the Book
**Excludes Sister Divisions

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